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Montana Morbidity Report

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Volume: 14:1 Month of: January, 1990

Montana State Department of Health and Environmental Sciences

* *
* HIV/AIDS INFORMATION *
* *

EDUCATION/CONFERENCES

Education Materials

The National Directory of AIDS Care, 1990 & 91 Ed. is being issued in March 1990. This is a desk reference filled with various AIDS-related resources and services. For more information call 1-800-933-0114.

CONFERENCES

May 3-6, 1990: Third Annual Conference, "AIDS Medicine and Miracles;" (303) 447-8777. Macky Auditorium, University of Colorado Campus. Dr. Elizabeth Kubler-Ross will be presenting a public lecture on "AIDS, the Ultimate Challenge."

May 8, 1990: "AIDS: Yes, A Women's Issue." Women's Lobbyists, Lewis and Clark Public Library, 7:00 - 8:30 p.m. To reserve child care, call 443-6387.

1990 AIDS Conference

The 1990 Montana Conference on AIDS will be held March 22 and 23, 1990 at the Strand Union Building on the Montana State University Campus in Bozeman. The cost for the two-day conference is $30.00, or $20.00 for one day. For more information, contact AHEC at 994-6001.

RESOURCES

The National Institute of Allergy and Infectious Diseases (NAIAD) has established a NIAID AIDS Clinical Trials Information Service. The computerized service provides current information, free of charge, about clinical trials sponsored by the National Institutes of Health (NIH) for AIDS patients and others infected with the human immunodeficiency virus (HIV). Callers may reach the service by dialing 1-800-TRIALS-A, Monday through Friday between 9:00 a.m. and 7:00 p.m., e.d.t.

Class Offering

The Montana Department of Health and Environmental Sciences, AIDS Program, announces a date for the next HIV Counselor Course. The course will be offered April 24-25, 1990 in Helena. This course is being offered to provide training for people involved in counseling persons who request the HIV test. For more information call Andrea Baumgardner or Rhonda Boyle at 444-4740.

Request For Proposal (RFP)

The U.S. Conference of Mayors is issuing a RFP for funding of community-based organizations (CBOs) to conduct education and services for persons with HIV.

Over $200,000 will be awarded to up to three established non-profit CBOs. For more information contact: The U.S. Conference of Mayors, 1620 Eye Street, N.W., Washington, D.C. 20006 or call (202) 293-7330.

TREATMENT AND RESEARCH

Mother-to-Infant Transmission of HIV-1

SUMMARY: In a prospective study of pregnant women infected with human immunodeficiency virus type 1 (HIV-1) in Brooklyn, New

York, U.S.A., 16 (29%) of 55 evaluable infants were infected with HIV-1. 9 infants had pediatric acquired immunodeficiency syndrome, 6 had less severe clinical manifestations of HIV-1 infection, and 1 was symptom-free but was seropositive for HIV-1 beyond 15 months of age. The 10 infants born at 37 weeks of gestation or earlier were at higher risk of HIV-1 infection than infants born at 38 weeks of gestation or later (60% vs. 22%) but the median age at appearance of disease was approximately 5 months in both groups. The HIV-1 transmission rate was not associated with predelivery levels of maternal T cells, anti-p24, or neutralizing antibodies but it was higher, among full-term infants, for those with mothers in the lowest third of the distribution of anti-gp120 levels (53%). On immunoblot, transmitting mothers lacked a gp120 band but not other bands. Protection was not associated with antibody to recombinant peptides from the hypervariable region of the major neutralizing gp120 epitope, and the anti-gp120 endpoint dilution titre was similar in transmitting and non-transmitting mothers. Mothers of uninfected full-term infants appear to confer immunological protection against HIV-1 infection of their offspring by way of a high-affinity antibody to a gp120 epitope, whose specificity has importance for vaccine development and possibly perinatal immunotherapy.

(The Lancet, 12/9/89, 1351-54)

New Labeling of AZT

On January 16, 1990, the HHS Secretary, Louis W. Sullivan, M.D., announced that the Food and Drug Administration has approved a change in the labeling for the anti-AIDS drug zidovudine, or AZT. The new labeling recommends administering the drug at long-term regimen of 600 milligrams a day -- half the previously recommended dose. This long-term regimen may be initiated after a patient has received one month of zidovudine therapy at a dose of 1200 mg a day.

The lower dose reflects results from a dose comparison study sponsored by the National Institute of Allergy and Infectious Diseases indicating that this dose was as effective as higher dose regimens in prolonging survival and reducing the frequency of opportunistic infections, and was less likely to produce severe adverse reactions. However, the effectiveness of the lower dose in improving the neurologic dysfunction associated with the AIDS virus infection is unknown.

HHS Assistant Secretary for Health, James O. Mason, M.D., Dr.P.H., also noted that the lower dose for zidovudine would reduce treatment costs. "Since the new approved dose will require only half the amount of zidovudine used at the previously recommended dose, the cost of zidovudine therapy should be halved for many patients," Dr. Mason said.

FDA's approval of a new recommended dose for zidovudine, which applies to both the capsule and syrup forms of the drug, does not prevent physicians from prescribing the drug at higher or lower dose levels when warranted.

* * * * *

According to Gwendolyn B. Scott, M.D. and colleagues, "children with perinatally acquired HIV-1 infection have a very poor prognosis" and "most become symptomatic before one year of age." The following abstract taken from the New England Journal of Medicine describes how this conclusion was drawn.

Abstract: We describe our experience at Jackson Memorial Hospital in Miami, Florida, with 172 children who were given diagnoses of perinatally acquired infection with human immunodeficiency virus type 1 (HIV-1). The 146 mothers of the children acquired HIV-1 through heterosexual contact (69 percent), intravenous drug use (30 percent), or blood transfusion (1 percent).

The children presented with symptomatic disease at a median age of eight months; only 21 percent presented after the age of two years. The most common first manifestations of disease were lymphoid interstitial pneumonia (in 17 percent), encephalopathy (in 12 percent), recurrent bacterial infections (in 10 percent), and candida esophagitis (in 8 percent), for which the median survival times from diagnosis were 72, 11, 50, and 12 months, respectively. Nine percent of the children had Pneumocystis carinii pneumonia at a median age of five months and had a median survival of only one month.

The median survival for all 172 children was 38 months from the time of diagnosis. Mortality was highest in the first year of life (17 percent), and by proportional-hazard analysis the probability of long-term survival is low. In multi-variate analyses, early age at diagnosis and the first identifiable pattern of clinical disease were found to be independently related to survival.

(N Eng J Med, 1989, 321:1791-6.)

* * * * *

In an article written in JAMA, Dr. King To of Lenox Hill Hospital and Dr. Alan H. Friedman of Mount Sinai School of Medicine in New York discuss the most common cause of vision loss for patients with AIDS -- cytomegalovirus (CMV) retinitis.

"The diagnosis of CMV retinitis is based on clinical examination and not on laboratory studies. A blood or urine culture positive for CMV is not helpful, since most AIDS patients without CMV retinitis already have CMV viremia or viruria. Careful and frequent ophthalmoscopic examinations by primary care physicians of patients who have AIDS or other patients who are immunocompromised are essential for early detection of CMV retinitis, since CMV retinitis is usually asymptomatic in the early stages of the disease. Prompt initiation of treatment with ganciclovir and foscarnet may reduce or prevent the significant and permanent visual loss often associated with CMV retinitis."

(JAMA, December 15, 1989, Vol. 262, No. 23, p. 3337.)

Treatment IND for Pediatric Zidovudine: The FDA has approved the distribution under a Treatment IND of zidovudine (also known as AZT) strawberry-flavored syrup in children between the ages of 3 months and 13 years who have acquired immunodeficiency syndrome (AIDS) or are suffering from symptoms of advanced infection with the AIDS virus. The clinical data indicate that the drug may prolong survival and relieve severe AIDS symptoms in children as it does in adults. The Treatment IND mechanism permits the use of promising investigational drugs in the treatment of patients with serious or life-threatening conditions for which there are no satisfactory alternative treatments.

Zidovudine will be distributed to eligible children under a Treatment IND protocol sponsored by the Burroughs Wellcome Company, Research Triangle Park, NC, with medical and technical assistance by the National Institute of Allergy and Infectious Diseases, a component of the National Institutes of Health. Physicians interested in enrolling patients in the Treatment IND protocol can call the sponsor at 1-800-829-PEDS from 8 a.m. to 7 p.m., eastern standard time.

AIDS Antigen Test: The FDA has approved licensing of a new diagnostic kit, HIVAG-1 and HIVAG-1 Blocking Antibody (Abbott Laboratories, Abbott Park, IL), to detect the presence of human immunodeficiency virus type 1 (HIV-1) in the serum and plasma. The test differs from other enzyme-linked immunoassay tests, particle agglutination test, or Western blot tests because it detects viral antigen, rather than antibodies formed by the immune system in response to the HIV-1 antigen. A correlation between detectable levels of HIV-1 antigen in the blood and the time to appearance of symptoms associated with the onset of AIDS-related complex or full-scale AIDS has been demonstrated by a number of studies. Therefore, the HIV-1 antigen test may be used as an aid in determining the prognosis of patients with HIV-1 infection. Other uses for HIV-1 antigen testing that have been reported are monitoring the presence of HIV-1 antigen in cocultures of peripheral blood lymphocytes and, in clinical research, monitoring treatment of HIV-1 infected individuals with antiviral drugs. The test is not intended as a screen for donated blood or plasma.

Since HIV-1 antibodies can take an average of 3 to 6 months to develop, the antigen test may detect the presence of the virus at an earlier point after infection than existing antibody tests, making it useful as a diagnostic test. Nevertheless, the test is not beneficial for screening blood donors. Extensive studies in the United States and Europe failed to show additional detection of HIV-1 infection in donors of whole blood in comparison with antibody testing. Although in separate studies plasmapheresis donors were found who exhibited the presence of HIV-1 antigen prior to antibody, current manufacturing processes assure that plasma derivatives do not transmit HIV-1, making additional screening for antigen unnecessary. For these reasons, the FDA acted in accord with the advice of its Blood Products Advisory Committee, which recommended against licensing of the antigen test for screening source plasma or blood donors.

The labeling for the antigen test kit emphasizes that AIDS and AIDS-related

conditions are clinical syndromes and that their diagnosis can only be established clinically. Human immunodeficiency virus type 1 antigen test results should be used as an adjunct to other information available to the physician.

Human immunodeficiency virus type 1 antigen is a low-sensitivity marker for detection of HIV-1 infection, since it is present only transiently prior to seroconversion and later becomes undetectable, probably because it is complexed by specific antibodies. Antigen testing should not be used in lieu of antibody testing as a screen for HIV-1 infection. In comparison with antibody testing, antigen testing will only detect approximately 50% of AIDS, 30% of AIDS-related complex, and 10% of asymptomatic HIV-1 infections.

The HIVAG-1 procedure for detection of HIV-1 antigen(s) has been demonstrated to have a very high specificity (99.82%). However, the predictive value of a positive test is strongly influenced by the prevalence of the condition in the population tested.

(Nightingale, Stuart L, M.D., JAMA, December 15, 1989, Vol. 262, No. 23, p. 3254.)

New AIDS/STD Program Manager Named

Bruce Desonia has been hired as the new manager of the AIDS/STD Program, replacing Richard Chiotti, who moved to the Office of Public Instruction. Desonia has been with the Communicable Disease Section of the Department over 16 years, starting as a Field Health Officer in Glendive and in Missoula. The last 2 1/2 years have been in Helena, focusing on the STD component of the AIDS/STD Program during the past 1 1/2 years.

*MONTANA
RESIDENT AND NON-RESIDENT AIDS CASES
Acquired Immunodeficiency Syndrome (AIDS)
Definitive and Presumptive AIDS Cases
Surveillance Report - 1/1/90 to 1/31/90

1. Disease Category

Disease Category	Adult/Adolescent Cases (%)	Deaths (%)
PCP	29 (50)	18 (51)
Other Disease w/o PCP	26 (44)	17 (49)
KS Alone	3 (6)	0 (0)
No Diseases Listed	0 (0)	0 (0)
Total	58 (100)	35 (100)

2. Age

Age	Cases (%)
Under 13	0 (0)
13-19	0 (0)
20-29	18 (31)
30-39	26 (44)
40-49	9 (16)
Over 49	5 (9)
Unknown	0 (0)
Total	58 (100)

3. Race/Ethnicity

Race/Ethnicity	Adult/Adolescent Cases (%)
White, Not Hispanic	53 (91)
Black, Not Hispanic	1 (2)
Hispanic	2 (3)
Native American	2 (3)
Unknown	0 (0)
Total	58 (100)

4. Patient Groups

Patient Groups	Adult/Adolescent Males (%)	Females (%)	Total (%)
Homosexual or Bisexual Men	35 (66)	0 (0)	35 (61)
Intravenous (IV) Drug User	6 (11)	0 (0)	6 (11)
Homo/Bi IV Drug User	6 (11)	0 (0)	6 (11)
Hemophiliac	3 (6)	0 (0)	3 (5)
Heterosexual Contact	0 (0)	4 (80)	4 (6)
Transfusion With Blood/ Products	0 (0)	0 (0)	0 (0)
None of the Above/Other	3 (6)	1 (20)	4 (6)
Total	53 (100)	5 (100)	58 (100)

Source: Montana AIDS Program, MDHES, through January 31, 1990.

*Includes 42 Montana AIDS cases and 16 cases reported to Centers for Disease Control from other states who are living in Montana.

As of January 31, 1990 there have been 239 positive HIV tests from 18,731 tests conducted through the MDHES Public Health Laboratory.

Nationally, as of December 31, 1989, 117,781 cases of AIDS and 70,313 deaths have been reported to the Centers for Disease Control.

JANUARY 1990	Campylobacter diarrhea	Chlamydia sexually transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead		2													
Big Horn		6	1												
Blaine		2													
Broadwater															
Carbon		2		1								1			
Carter															
Cascade		14									7	1			
Chouteau															
Custer		1													
Daniels															
Dawson	1	1					1								
Deer Lodge		1													
Fallon															
Fergus		1													
Flathead		2	2			1	1								
Gallatin		16			1	1					4				
Garfield											1				
Glacier		3		1											
Golden Valley															
Granite															
Hill		8	1												
Jefferson		3													
Judith Basin															
Lake		1			1										
Lewis & Clark		12	1	3									1		
Liberty															
Lincoln		1													
McCone															
Madison															
Meagher															
Mineral															
Missoula		13	1							1					
Musselshell															
Park			1												
Petroleum															
Phillips															
Pondera											1				
Powder River															
Powell			1							1					
Prairie															
Ravalli				1							1		1		
Richland															
Roosevelt		12		2		1									
Rosebud		2		2											
Sanders				1							1				
Sheridan															
Silver Bow		6													
Stillwater		1													
Sweet Grass															
Teton							1								
Toole															
Treasure															
Valley												1			
Wheatland															
Wibaux															
Yellowstone		20		2									3	2	
MONTHLY TOTAL 1990	1	133	8	12	2	3	3	0	0	2	15	3	5	2	0
MONTHLY TOTAL 1989	1	128	4	27	1	4	11	0	0	0	3	8	2	12	0
MONTHLY TOTAL 1988	2	224	4	32	1	5	6	1	2	0	12	17	3	12	0
TOTAL TO DATE 1990	1	133	8	12	2	3	3	0	0	2	15	3	5	2	0
TOTAL TO DATE 1989	1	128	4	27	1	4	11	0	0	0	3	8	2	12	0
TOTAL TO DATE 1988	2	224	4	32	1	5	6	1	2	0	12	17	3	12	0

OTHER DISEASES: Amebiasis: Sheridan, 1; Aseptic Meningitis: Sanders, 1; Bacterial Meningitis: Missoula, 1; Chickenpox: Hill, 9; Judith Basin, 10; Cytomegalo Viral Illness: Beaverhead, 1; Primary Syphilis: Yellowstone, 1

Update on Tuberculosis in Montana

The final tabulations on number of cases for 1989 are available for some of the reportable diseases. Tuberculosis was reported as new active cases in 31 persons during 1989. This compares to the last four years in the following manner:

1988	--	39 cases
1987	--	21 cases
1986	--	34 cases
1985	--	50 cases

Ideal tuberculosis control and containment would see the number of cases decreasing by 4% per year. This has not happened. Other indicators besides number of cases are important in evaluating risk of tuberculosis in an area. Numbers of cases occurring in children is a sensitive piece of data since children have to have been infected in recent years opposed to elderly persons who may have been infected decades ago. There was only one case of tuberculosis reported in Montana in 1989 for a person less than 25 years of age. This is an improvement since 1988 when multiple cases in persons under 25 were reported. Unlike the national data, Montana had more cases reported in females in 1989 than in males.

The index of suspicion for tuberculosis is very low and although a complete study with statistical analysis of the data has not been done, observation of information about each case of tuberculosis reported to MDHES has indicated several items worthy of note. It's not unusual for cases to be diagnosed as having another problem such as unresolving bacterial pneumonia for time periods as long as several months. These patients are seeking care in various health care situations for their unresolving condition and present at doctor's offices and medical facilities when they may be infectious with tuberculosis. A recent specific example is of an elderly patient hospitalized in an acute care setting for a number of weeks who was eventually found to have smear-positive pulmonary tuberculosis.

Tuberculosis control requires a sustained systematic approach. The approach has been well-defined and outlined by the Centers for Disease Control and the American Thoracic Society. Documents detailing tuberculosis prevention and control as proposed by these two organizations are available from MDHES and can be obtained by phoning the Communicable Disease Section at 444-4740.

Immunization Wallet Card Revised and Available to All Clinics

The Official Montana Immunization Record card has been revised. Blue Cross and Blue Shield of Montana continues to support the prevention effort in the area of immunization and, again, has provided the printing of the card. They also are involved in the development of educational tools to be used in public and private clinics in the use of the card.

The card is available to all immunization providers, public and private. All persons who receive vaccinations in Montana, regardless of vaccine type, should be provided the Official Montana Immunization Record and have each vaccination documented on it.

A supply of the card will be available to all clinics through the county health departments.

Some of the changes made (not found in our previous card) are:

- it's a lifetime card;
- it has specific areas to document influenza and pneumococcal vaccines;
- tetanus, diphtheria and pertussis combination vaccines can be differentiated;
- measles, mumps and rubella combination vaccines can be differentiated;
- up to three doses of MMR can be documented;
- two doses of Hib vaccine can be documented;
- a grid format for documenting influenza immunizations can cover 32 years of flu shots;
- pneumococcal vaccine is documented adjacent to the influenza grid for quick assessment of high risk persons;
- there is no immunization schedule included, so the card won't outdate as quickly as in the past; and
- the front of the card says "Place in your wallet" and "This is a lifetime legal record. Don't lose it. If found, return this card to the nearest health department".

(Tri-fold)

Front

PLACE IN YOUR WALLET

State of Montana

OFFICIAL MONTANA IMMUNIZATION RECORD

Blue Cross
Blue Shield

NAME

BIRTHDAY

ALLERGIES

THIS IS A LIFETIME LEGAL RECORD. DON'T LOSE IT.
IF FOUND RETURN THIS CARD TO THE NEAREST HEALTH DEPARTMENT.

Back

MONTANA DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES (Rev 1/90)

Pneumococcal (Mo./Day/Yr.)

INFLUENZA (one each year)				
DATE GIVEN RECORD ONLY Mo./Day/Yr.)				

OTHER VACCINES	DATE GIVEN (Mo./Day/Yr.)	DOCTOR OR CLINIC	DATE NEXT DOSE DUE

ATTENTION PARENTS

All parents want their children to be free of disease. We urge you to discuss with your local health department and family doctor how your children can best be protected from diseases.

Inside

NAME

SEX BIRTHDAY

VACCINE(S)	DTP	ADULT Td	DT	DATE GIVEN (Mo./Day/Yr.)	DOCTOR OR CLINIC	DATE NEXT DOSE DUE
Tetanus Diphtheria Pertussis (✓ type given)	1					
	2					
	3					
	4					
	5					
	6					
	7					
	8					
	9					

	ME	MU	RU	DATE GIVEN (Mo./Day/Yr.)	DOCTOR OR CLINIC	DATE NEXT DOSE DUE
Measles Mumps Rubella (✓ type(s) given - example MMR = ✓✓✓)	1					
	2					
	3					

	DATE GIVEN (Mo./Day/Yr.)	DOCTOR OR CLINIC	DATE NEXT DOSE DUE
Polio (trivalent)	1		
	2		
	3		
	4		
	5		
	6		

	DATE GIVEN (Mo./Day/Yr.)	DOCTOR OR CLINIC	DATE NEXT DOSE DUE
Hib	1		
	2		

TB Test

NOTES

An Update on Hepatitis B Cases Reported in Montana

The final count for cases of hepatitis B reported in 1989 is 50. This compares to reports from 1988 of 55 cases, 1987 - 59 cases, 1986 - 51 cases, and 1985 - 61 cases. Although there is a small variation in these numbers, the actual number of cases is not significantly different. Upon analysis of data submitted regarding cases, the following was found: 40% of cases were reported from two counties in 1989. Lewis and Clark and Missoula counties each reported 10 cases of hepatitis B. Yellowstone County was next in line in reporting of seven cases. The mean age of cases of hepatitis B reported in 1989 was 39 years of age. The number of cases was nearly evenly divided between sexes. Date of onset analysis showed no specific instances of peaks in reporting with the cases being spread out as being reported throughout the year.

National data and data obtained by our office indicate that hepatitis B vaccine is still under-utilized. There are now two manufacturers of hepatitis B vaccine marketing the product. Although the price can be negotiable when a group is buying a large quantity of vaccine, the hope for a large reduction in price has not materialized. One must weigh the cost of hepatitis B vaccine at its current price to the cost of hepatitis B disease. The costs of hepatitis B disease far outweigh the costs of hepatitis B vaccine without considering the human suffering costs into the figures in any sense. MDHES recommends hepatitis B vaccine for all persons in high risk groups. These are persons likely to be exposed to blood in work settings, the infants of mothers who are hepatitis B carriers, and sexually active and IV drug sharing populations. MDHES Public Health Laboratory provides screening for routine prenatal care. This allows the health care provider to administer appropriate prophylaxis to newborns of hepatitis B infectious mothers and prevent the child from becoming a hepatitis B case and, in a high percentage, a new carrier. Breaking the chain of hepatitis B transmission will require implementation of guidelines from the American Committee on Immunization Practices and the Centers for Disease Control. These have been published and updated in various issues of the "Morbidity and Mortality Weekly Report" from Centers for Disease Control. Anyone wishing more information regarding hepatitis B prevention should call the Communicable Disease Section at 444-4740.

Volume: 14:1 **Month of:** January, 1990

MONTANA MORBIDITY REPORT. ISSN =0745-5129 Published monthly with an extra issue for March by the Health Services Division of the Department of Health and Environmental Sciences, Cogswell Building, Helena, MT 59620. (406)444-4740

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MONTANA MORBIDITY REPORT

Montana Morbidity Report

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Volume 14:2 February, 1990

Montana State Department of Health and Environmental Sciences

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* HIV/AIDS INFORMATION *
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EDUCATION/CONFERENCES

Conferences:

May 3-6, 1990: Third Annual Conference, "AIDS Medicine and Miracles," Macky Auditorium, University of Colorado, (303) 447-8777.

May 4, 1990: Third Annual AIDS Forum, "Risky Business: Talking With Teens About Intimacy in the Age of AIDS." Jay Friedman from Burlington, Vermont will be conducting the workshop. It will be held at St. Patrick's Hospital in Missoula. Call Karen Ward at 523-4775 for more information.

Class Offering:

April 24-25, 1990: "HIV Counselor Course," Helena, MT. To register call Andrea Baumgardner or Rhonda Boyle at 444-4740.

RESOURCES

Directory of Antiviral and Immunomodulatory Therapies for AIDS

The CDC AIDS Weekly has recently written a two-part directory of antiviral and immunomodulatory therapies for AIDS called DAITA for short. This directory is a guide to current and past research of therapies under investigation for AIDS. This directory would be appropriate for direct care providers and others interested in reading detailed information about the various therapies under investigation. This guide does not make treatment recommendations.

To order this two volume set call or write Rosie London at:

CDC AIDS Weekly
P. O. Box 830409
Birmingham, Alabama 35283-0409
1-800-633-4931

The cost is $30.

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"Learning AIDS" is an information resource directory recently released by the American Foundation for AIDS Research. The directory is conveniently arranged by target audience to help you rapidly identify the best materials to fit your audience's needs. For more information call toll-free 1-800-521-8110. ($24.95 each plus $3.50 for shipping and handling.)

TREATMENT AND RESEARCH

Expanded Surveillance of Workers with Occupational Exposures to HIV

CDC has expanded its on-going surveillance of workers with occupational exposures to HIV to collect additional information on post-exposure chemoprophylaxis. No names or other personal identifiers of workers are collected.

Information is collected on the following:

-- circumstances associated with exposures
-- extent to which zidovudine and other antiretroviral agents are prescribed for post-exposure chemoprophylaxis, including dosage and timing
-- incidence of associated toxicity
-- rate of HIV seroconversion among workers who do and do not receive post-exposure chemoprophylaxis

All physicians who provide care to a worker within 1 month after an occupational expos-

ure to HIV, regardless of whether an antiretroviral agent is prescribed, are encouraged to enroll the worker in the CDC surveillance system. Enrollment and follow-up requirements have been simplified; in particular, it is no longer necessary to send blood specimens to CDC for HIV serologic testing unless the enzyme immunoassay (EIA) performed by a licensed local laboratory is reactive or equivocal. CDC will continue, however, to offer EIA testing at no charge on specimens from surveillance participants on request. Additional information and enrollment materials can be obtained from the Hospital Infectious Program, Center for Infectious Diseases, Centers for Disease Control, Mail Stop C-10, Atlanta, GA 30333; telephone (404) 639-1644.

Contacts for Physicians and for Infection Control and Occupational Health Professionals

-- To enroll persons who have had a "massive exposure" to HIV in NIAID study of zidovudine prophylaxis, telephone (800) 537-9978.

-- To report adverse effects associated with zidovudine to FDA, use "Adverse Reaction Report" forms (FDA #1639), obtainable from: Food and Drug Administration, Office of Epidemiology and Biostatistics, HFD-7300, Rockville, MD 20857; (301) 443-4580.

-- To enroll an exposed worker in the CDC prospective surveillance system, telephone (404) 639-1644.

-- To enroll pregnant women who receive zidovudine during pregnancy, contact: Zidovudine in Pregnancy Registry, Epidemiology, Immunization and Surveillance Division, Burroughs-Wellcome Company, 3030 Cornwallis Road, Research Triangle Park, NC 27709; (919) 248-8465 (collect) or (800) 722-9292.

(From MMWR, CDC, 1/26/90, Vol. 39, No. RR-1.)

Program Changes/Updates

Sandi Sonsteng was recently hired by the Montana AIDS/STD Program as the new Administrative Aide. Sandi's previous job was with the Montana Developmental Center in Boulder where she was employed for 5 years. She has already proved to be an asset to the Program.

The Montana AIDS Review Panel met in Helena on February 14, 1990. The following materials and videos were approved by the panel:

Videos: "Teen Aids: In Focus"
"On the Front Line"
"Protect Yourself"

Materials:

Native American pamphlets entitled, "Teach Children/Warn," AIDS Not Immune," and "Empty Cradle Board," produced and submitted by MUIA were approved with one change by seven Panel members. (The change was to delete the term "ARC" from the pamphlets.)

Andrea presented the first, second, and third place winners of the Native American posters content produced and submitted by Montana United Indian Alliance with permission from the artists. Seven Panel members approved the posters for reproduction.

A pamphlet, "Talking About AIDS" (for Hispanics), submitted by the Billings AIDS Support Network was approved by seven Panel members.

A booklet, "Nutrition and HIV: Your Choices Make a Difference" was approved. The Montana AIDS Program is in the process of printing the booklet which was produced and made available by the Tennessee Department of Health and Environment.

Pending Approval:

"Guidelines for Communicable Disease Control Policies in Montana Schools" (OPI)

Video: "Needle Talk"

IVDU/AIDS Survey Questionnaire

A booklet, "Saturday Night Specials: A Story of Choices," submitted by the Montana Migrant Health Council is pending approval until Panel members have the opportunity to review the booklet.

The next AIDS Review Panel meeting is tentatively set for May 16, 1990.

Four 30 second PSA's promoting the Montana AIDS Hotline will be released in March. If you have any questions or comments regarding the Hotline, please direct them to the AIDS/STD Program by calling 444-3565.

* * * * * * * *

Mrs. Kay Marshall, R.N. is now coordinating HIV-positive information for the Medicaid Drug Program in the Department of Social and Rehabilitation Services (SRS). Her phone number if 444-4540.

MUIA Receives 1 of 23 National AIDS/HIV Education Grants

The Montana United Indian Association received a grant from the U.S. Conference of Mayors for community-based projects in the U.S. Selections were made from 393 proposals submitted from 18 states and funding was through the Centers for Disease Control.

The Montana United Indian Association (MUIA) was incorporated in 1971 with the mission to promote, protect, and develop the overall welfare of the Native American community in Montana. Presently, MUIA is developing HIV/AIDS training materials (brochures, videos, posters and pamphlets) for urban Native Americans under funding from the Montana Department of Health and Environmental Sciences.

MUIA will utilize funding to expand and enhance outreach and training in the cities of Helena and Great Falls, Montana, as well as on reservations. Major activities will include training of 20 Community Health Representatives (adults) and 30 Native American high school students who will provide culturally sensitive peer education in their communities. From the training process, a culturally sensitive HIV/AIDS Train the Trainer manual will be developed and disseminated among Native American organizations on area reservations. MUIA anticipates this manual will become a model for replication among other Native American populations.

Additionally, the program will employ two "street-wise" urban outreach workers to reach Native Americans engaging in high risk activities in urban areas. The outreach workers will concentrate their efforts in bars and areas where Native Americans congregate. The outreach component of the project will be a collaborative effort between MUIA, the Billings Urban Center and the Great Falls Urban Center. MUIA anticipates making one-on-one contact with over 500 Native Americans during the project period.

Their address is: MUIA, P. O. Box 6034, Helena, MT 59604 (406) 443-5350.

A TUBERCULOSIS CLUSTER UNDER INVESTIGATION

State and county officials cooperatively began investigating a cluster of tuberculosis cases in Cascade County in late February. Four cases have been identified which may be related, based on common exposures and one other case which may not be related. There have been 101 close contacts identified and of those screened, 30% have reacted with positive PPDs. The investigation and surveillance are ongoing at this time.

The four cases and a majority of the contacts are frequent visitors to one of two homeless shelters and many are homeless individuals who eat the majority of their meals at such shelters but sleep elsewhere. A high prevalence of this illness is not unexpected in such populations.

In several areas of the nation outbreaks have been reported in shelters for the homeless. To address this problem, the Centers for Disease Control in Atlanta, have issued several recommendations, which are also relevant to the current Montana situation. The recommendations appears in Archives of Internal Medicine, 1988: 148:1843.

> "(1) Tuberculosis should be suspected and sputum samples should be collected from any homeless individual with a productive cough. (2) Diagnosed or suspected tuberculosis in a homeless individual should be immediately reported to the health department. (3) Therapy should be fully supervised by a responsible person and an intensive multi-drug, six-month regimen should be utilized whenever possible. (4) A contact investigation should be conducted around each infectious case and preventive therapy should be prescribed for high-risk infected individuals. (5) Shelter staff should receive a tuberculin skin test when they start work and every six to 12 months thereafter. (6) Skin test reactors should be considered for preventive therapy according to current guidelines. (7) Installation of ultraviolet lights to reduce transmission should be considered in some situations."

UPDATE: RECENT INFORMATION ON EOSINOPHILIA-MYALGIA-SYNDROME ASSOCIATED WITH L-TRYPTOPHAN INGESTION

According to CDC's Morbidity and Mortality Weekly Report, Vol. 39, No. 6, and update briefings from CDC and FDA, new cases of EMS continue to be reported despite the FDA recall and considerable publicity. There are indications that some of the cases began taking L-tryptophan (LT) after the November 1989 announcements or continued to use LT from stocks on hand at the time of the recall.

Case Reports

The number of cases continues to rise and was at 1,269 cases by February 9, 1990, as reported by state and territorial health departments. State totals are as follows:

AL:	11	IL:	38	MT:	4	RI:	3
AK:	1	IN:	13	NE:	6	SC:	29
AZ:	46	IA:	5	NV:	8	SD:	1
AR:	4	KS:	2	NH	8	TN:	11
CA:	236	KY:	8	NJ	10	TX:	68
CO:	32	LA:	1	NM:	29	UT:	5
CT:	11	ME:	5	NY:	119	VT:	1
DE:	3	MD:	24	NC:	24	VA:	11
DC:	3	MA:	18	ND:	2	WA:	43
FL:	69	MI:	14	OH:	49	WV:	9
GA:	21	MN:	60	OK:	19	WI:	24
HI:	3	MS:	9	OR:	61	WY:	3
ID:	6	MO:	24	PA:	52	PR:	3

Although several deaths are being investigated for confirmation of EMS and LT status, the total number of reported deaths of EMS patients known to have been taking LT prior to illness onset remains at 13, as of February 20.

Surveillance Information

A case of EMS taking niacin but not taking LT was reported to CDC from the Mayo Clinic recently. This is of particular interest since niacin is in the metabolic pathway of tryptophan and may be produced by processes similar to those used to make LT. FDA has been notified and is in the process of investigating and obtaining samples. If you hear of similar cases, please let us know.

The investigations by FDA, CDC and other public health agencies have not been able to link the outbreak of illnesses and deaths to any specific lot, brand, manufacturer or supplier or L-tryptophan, nor have extensive laboratory analyses of products have been able to identify a specific chemical or microbial contaminant responsible for the outbreak. Cases have been reported in all 50 states, plus the District of Columbia and Puerto Rico.

An article in the January 31 issue of the Wall Street Journal entitled "CDC Suspects Contamination in Rare Disease" implies that CDC has made a recent breakthrough discovery and now knows the specific causal agent of eosinophilia-myalgia syndrome. This is not so. Also, contrary to the further implication of the article and to the best of our knowledge, final results are not yet available from any of the ongoing LT trace-back studies. Thus, we do not consider that there is currently any conclusive evidence linking the EMS problem with LT from any particular company or source.

Legal and Regulatory Status

In a "Dear Colleague" letter of January 17, 1990, FDA advised discontinuance of the use of LT as a dietary supplement and requested recall of products providing 100 mg or more of manufactured L-tryptophan and advising against its use as an over-the-counter supplement. In another similar letter received in February, FDA's Stuart L. Nightingale, M.D., Associate Commissioner for Health Affairs, updated the January 17 letter. " . . .On page 2 of that (January 17, 1990) letter, it was suggested that over-the-counter L-tryptophan dietary supplements that provide for the intake of less than 100 mg daily were lawfully marketed. This is incorrect. While the FDA has not asked for a recall of those products, L-tryptophan is not approved for use in dietary supplements. There are only two types of approved uses of LT as a nutrient: (1) as an additive in food containing naturally occurring primarily-intact protein that is considered a significant dietary protein source; and (2) as an additive in special dietary foods that are intended for use solely under medical supervision to meet nutritional requirements in specific medical conditions (21 CFR 172.320). Neither approved use provides for the marketing of LT as a component of an over-the-county dietary supplement.

On page three of the January 17, 1990 letter, it was suggested that L-tryptophan is generally recognized as safe and effective for use as a nutritional replacement. This is incorrect. The FDA does not consider L-tryptophan as generally

recognized as safe and effective for any use. L-tryptophan is an approved food additive when used, as described above, for nutritional purposes."

Treatment of EMS

In CDC's February 16, 1990 issue of MMWR, the California Department of Health Services (CDHS) discussed treatment briefly. "Although CDHS did not systematically collect information on treatment modalities, some physicians reported to CDHS that corticosteroids often decreased the eosinophilia but had less effect on the myalgia. Subcutaneous heparin reported relieved muscle pain in some patients. Plasmapheresis was attempted in one California EMS patient with progressive polyneuropathy; some improvement of motor symptoms occurred initially, but symptoms relapsed when plasmapheresis was discontinued, and a second course was ineffective. Because the information reported to CDHS is anecdotal only, CDHS has not recommended any specific medical therapy other than general supportive care and discontinuation of LT use."

An editorial by the CDC appeared in the Annals of Internal Medicine, "Interim Guidance on the Eosinophilia-Myalgia Syndrome", Vol. 12, No. 2, January 12, 1990. That editorial offers information on therapy for EMS.

STD ATLAS AVAILABLE

The Montana STD Program has a Wellcome atlas of sexually transmitted diseases available for professional use. If interested, call or write the Montana STD Program for your Burroughs Wellcome Co. representative.

AIDS Drug Reimbursement Program

The Montana AIDS/STD Program has received a $30,000 grant for calendar year 1990 from the Department of Health and Human Services to "pay for the cost of FDA-approved drugs determined to prolong life and prevent serious deterioration of health arising from AIDS or HIV infection." Applicants may request an application form by writing to the Montana AIDS/STD Program, c/o ADRP, Cogswell Building, Helena, MT 59620.

Public Clinics to Order Vaccine by March 23, 1990

The Immunization Program will be receiving vaccine orders for mailing vaccine during the weeks of March 26 and April 2.

The vaccine clerk for the Program has accepted a new position in the Department. The position may not be filled on a full-time basis until after May 1st. After that date, the new person will need to be trained. The training period could carry on into the summer "no vaccine shipment" months.

Written vaccine orders must be received by the program by Friday, March 23, 1990.

Plan on vaccine storage needs. Oral polio vaccine can require quite a bit of storage space. A small freezer may not hold enough polio vaccine to carry clinics through September.

1 cubic foot of freezer space will hold approximately 31 boxes (1550) doses) of oral polio vaccine.

MONTANA AIDS HOTLINE

Montana AIDS/STD Program supports a Montana AIDS hotline; 1-800-233-6668 which offers information 24 hours a day on the following subjects: 1) how AIDS is spread, 2) protecting yourself, 3) risk factors, 4) HIV antibody test, 5) symptoms and treatment, 6) condom use, 7) referrals for more information and 8) Montana statistical data. We are in the process of assessing and evaluating the information available. If you have any suggestions or comments, please call or write the AIDS/STD Program, 444-4740.

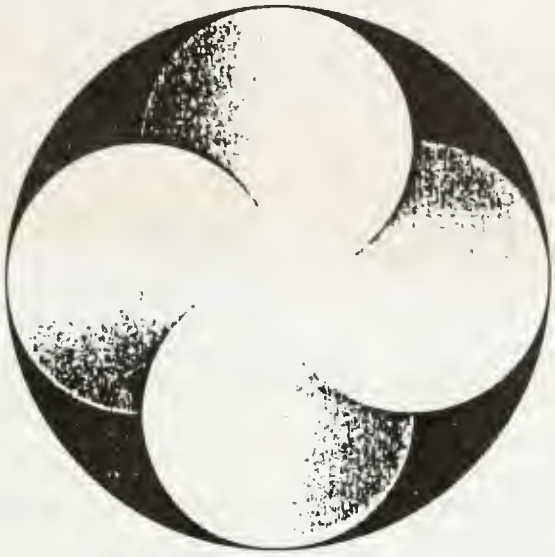
ERRATA:

In the January 1990 issue the date shown for "AIDS: Yes, a Women's Issue" was incorrectly listed as May 8, 1990, but was scheduled for March 8, 1990.

FEBRUARY 1990	Campylobacter, diarrhea	Chlamydia, sexually transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non A, Non B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead		4													
Big Horn		1		1											
Blaine		1					5						1		
Broadwater															
Carbon												1			
Carter															
Cascade		18	2	1	1							1			
Chouteau															
Custer		2													
Daniels															
Dawson															
Deer Lodge			1												
Fallon															
Fergus															
Flathead	1	3	2			2									
Gallatin		17	3	1									1		
Garfield															
Glacier				2		4		1	1						
Golden Valley															
Granite															
Hill		9				5	4						1		
Jefferson		1													
Judith Basin															
Lake		6		4		2								1	
Lewis & Clark		7								1					
Liberty															
Lincoln															
McCone															
Madison															
Meagher															
Mineral															
Missoula		15	2	5		2	1								
Musselshell													1		
Park				1											
Petroleum															
Phillips															
Pondera															
Powder River															
Powell		2					1								
Prairie															
Ravalli		3													
Richland												1			
Roosevelt		7		1											
Rosebud		4													
Sanders		3													
Sheridan		1													
Silver Bow		3													
Stillwater															
Sweet Grass		1													
Teton			1								2	1			
Toole															
Treasure															
Valley															
Wheatland															
Wibaux															
Yellowstone		18		1			1						1	2	
MONTHLY TOTAL 1990	1	126	11	17	1	15	12	1	1	1	2	4	5	3	0
MONTHLY TOTAL 1989	6	120	11	18	0	4	1	1	0	0	7	4	12	23	0
MONTHLY TOTAL 1988	3	176	29	37	2	9	4	0	0	0	4	17	5	0	0
TOTAL TO DATE 1990	2	259	19	29	3	18	15	1	1	3	17	7	10	5	0
TOTAL TO DATE 1989	7	248	15	45	1	8	12	1	0	0	10	12	14	35	0
TOTAL TO DATE 1988	5	400	33	69	3	14	10	1	2	0	16	34	8	12	0

OTHER DISEASES: Amebiasis: Gallatin, 1.
Chickenpox: Cascade-5; Hill-6; Judith Basin-12; Meagher-3; Yellowstone-1.
Cytomegaloviral Illness: Ravalli-1

1990 MPHA CONFERENCE



FULL CIRCLE:

PAST➤PRESENT➤FUTURE
OF PUBLIC HEALTH

Planning for the 1990 Montana Public Health Association (MPHA) annual meeting is well underway. The conference will be held April 11-13, 1990 at the Park Inn (Yogo Inn) in Lewistown. This year's theme is: "Full Circle: Public Health Then and Now." Keynote speakers will be Myron Allukian, President of the American Public Health Association and Gary Kukula from the National Rural Health Association. Plan now to attend!

APRIL 11-13, 1990 • LEWISTOWN, MONTANA

Local MR Vaccine

Several local immunization programs have purchased Measles-Rubella vaccine during the past two years, either with MCH or county funds and extensive re-immunization has been conducted for those immunized prior to 15 months of age or otherwise in need of immunization.

Those local clinics which are in possession of MR vaccine in excess of their current needs are urged to contact the Montana Immunization Program (R. Paulsen) at 444-4740 if you would like to arrange to sell or transfer this vaccine to another county. Likewise, programs with funding to purchase MR vaccine should make these desires known. The state program will be happy to act as facilitators for such transactions but is not in a position to buy and resell the vaccine.

Additional monies from CDC for the purchase of vaccine this year are not expected.

*MONTANA RESIDENT AND NON-RESIDENT AIDS CASES

Acquired Immunodeficiency Syndrome (AIDS)
Definitive and Presumptive AIDS Cases
Surveillance Report - 1/1/90 to 1/31/90

1. Disease Category

	Adult/Adolescent Cases (%)	Deaths (%)
PCP	29 (50)	18 (51)
Other Disease w/o PCP	26 (44)	17 (49)
KS Alone	3 (6)	0 (0)
No Diseases Listed	0 (0)	0 (0)
Total	58 (100)	35 (100)

2. Age

	Cases (%)
Under 13	0 (0)
13-19	0 (0)
20-29	18 (31)
30-39	26 (44)
40-49	9 (16)
Over 49	5 (9)
Unknown	0 (0)
Total	58 (100)

3. Race/Ethnicity

	Adult/Adolescent Cases (%)
White, Not Hispanic	53 (91)
Black, Not Hispanic	1 (2)
Hispanic	2 (3)
Native American	2 (3)
Unknown	0 (0)
Total	58 (100

4. Patient Groups

	Adult/Adolescent Males (%)	Females (%)	Total (%)
Homosexual or Bisexual Men	35 (66)	0 (0)	35 (61)
Intravenous (IV) Drug User	6 (11)	0 (0)	6 (11)
Homo/Bi IV Drug User	6 (11)	0 (0)	6 (11)
Hemophiliac	3 (6)	0 (0)	3 (5)
Heterosexual Contact	0 (0)	4 (80)	4 (6)
Transfusion With Blood/ Products	0 (0)	0 (0)	0 (0)
None of the Above/Other	3 (6)	1 (20)	4 (6)
Total	53 (100)	5 (100)	58 (100)

Source: Montana AIDS Program, MDHES, through January 31, 1990.

*Includes 42 Montana AIDS cases and 16 cases reported to Centers for Disease Control from other states who are living in Montana.

As of January 31, 1990 there have been 239 positive HIV tests from 18,731 tests conducted through the MDHES Public Health Laboratory.

Nationally, as of December 31, 1989, 117,701 cases of AIDS and 70,313 deaths have been reported to the Centers for Disease Control.

Volume: 14:2 Month of: February, 1990

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VOLUME 14-3 MARCH 1990

Montana State Department of Health and Environmental Sciences

First Measles case for 1990 Reported in Montana

A 25 year old male, with a rash onset of March 16, was reported as the first measles case in Montana since December 30, 1988. He arrived in Helena from a state where measles has been occurring. Although the person was infectious while in Montana, no spread cases have been identified as of April 4, 1990. This person had never been immunized against measles.

Measles in the United States: Update for week ending March 24, 1990

-3,377 measles cases reported. This compares to 1,941 cases during the same time period in 1989 or a 74% increase in reported cases.

-27 measles related deaths have been reported. This compares with a total of 45 measles-related deaths reported all of last year.

-Most outbreaks are occurring in pre-schoolers.

-There are currently 72 measles outbreaks in the continental U.S.

-22 states have outbreaks occurring.

States, near Montana, with current outbreaks include:

Washington -- cases are reported in Yakima, Seattle, Tacoma, Ellensburg and communities north of Vancouver. Suspect cases are reported in the Tri-cities area, and in north-central Washington. It is estimated that 90% of the cases are in hispanic groups and approximately 70% are spread from persons who imported the disease from out of the United States. Nosocomial spread, including hospital employees, is playing an important part in the Washington outbreaks. In one hospital, two physicians who are part of the emergency trauma team were cases;

Oregon -- Cases are reported in Eugene, including the University of Oregon, Forest Grove, near Portland, including Pacific University, in the community and a migrant camp;

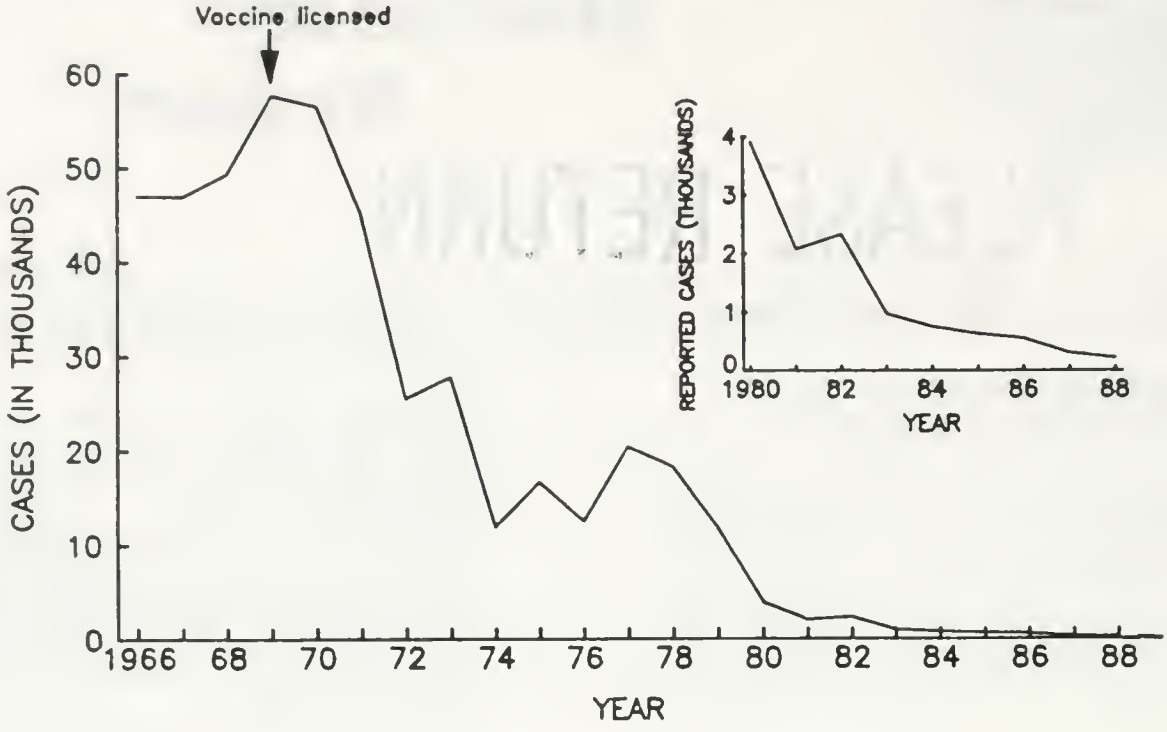
Idaho -- Cases are reported in the Twin Falls area and west of Twin Falls. Ages range from 2 to 12 years. Most cases are in hispanic groups. Hospital exposure has occurred.

Note: Mexico has had a continuing outbreak of measles. In 1989, there were more than 15,000 cases and more than 1000 measles-related deaths in Mexico. The Washington and Idaho outbreaks are associated with large groups of families entering the U.S. Apparently, the amnesty program now allows new citizens to bring family members into this country.

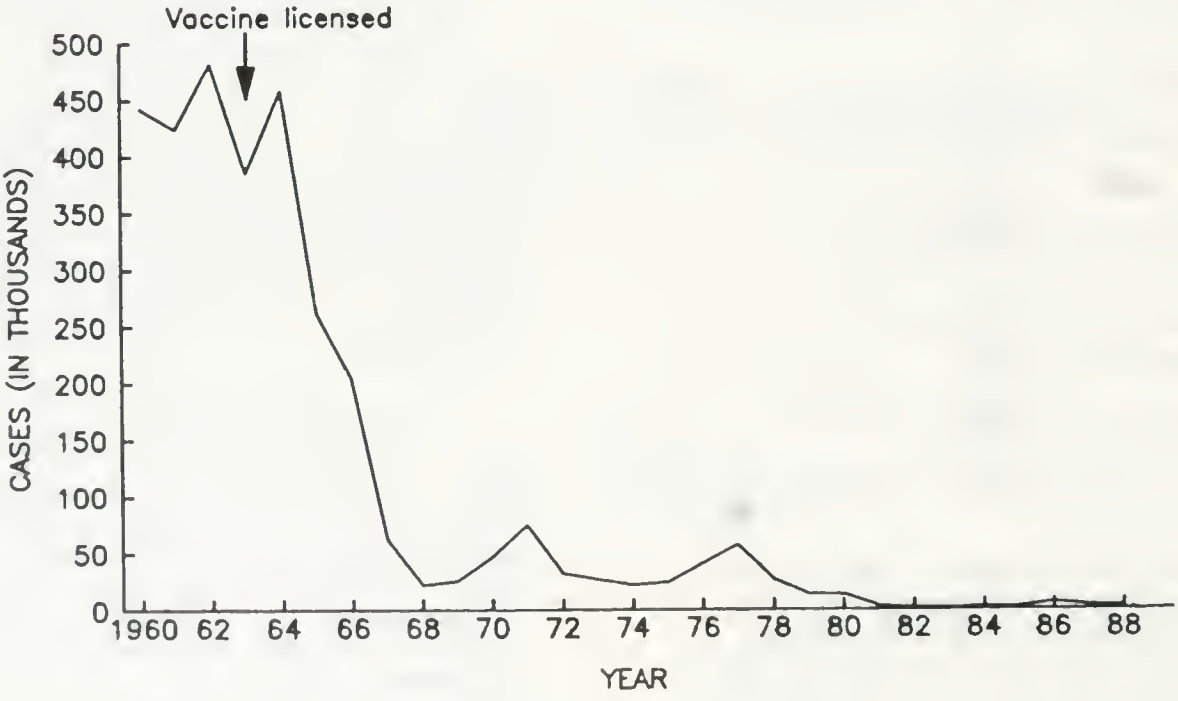
Idaho Mumps Outbreak Continuing

There have been more than 50 cases of mumps reported in the Pocatello area since November 1989. Idaho Falls has reported 27 mumps cases in the two week period March 19 through April 4. Fifteen (55%) of the 27 recent cases have a documented history of one mumps immunization. Junior High and High School students comprise the majority of the Idaho mumps cases.

Reported Rubella Cases
United States, 1966–1988



Reported Measles Cases
United States, 1960–1988*



Measles Outbreak Control Measures Implemented at St. Peters Community Hospital, Helena

During March, a measles case was hospitalized at St. Peters Community Hospital. To reduce the potential for spread of the disease to hospital employees, the new ACIP recommendations for measles control were used. Within 1 day of the person being hospitalized, 200 employees were identified as being susceptible to measles. Persons born before January 1, 1957, were considered immune.

Control efforts in the hospital resulted in the following prevention measures:

1) 141 employees were immunized within 72 hours;
2) 30 employees, who were pregnant and lacking proof of immunity, had measles immunity testing done by a private lab. 3 of them were identified as not being immune and will remain off work until April 9, unless additional cases are identified in the hospital. They will be immunized after delivery and prior to their return to work following the delivery;
3) 8 employees refused immunization and were tested for immunity. They were allowed to return to work after the testing results were obtained and they were determined to be immune;
4) No volunteers were allowed in the building who were susceptible;
5) 15 employees who were on leave status will be vaccinated before return to work;
6) 3 employees remain to be vaccinated at this time and have not returned to work;
7) 1 employee remains on furlough until they are vaccinated.

The vaccine used to vaccinate these employees was MMR. The vaccine was provided to the employees by St. Peters Hospital. Clinics were held at the hospital.

The Measles Prevention: Recommendations of the ACIP are found in the December 29, 1989 issue of the MMWR. A summary of this recommendation, as used to control measles in a hospital, follows:

> Outbreak Control -- Control activities should not be delayed for laboratory results on suspected cases. Persons who cannot readily provide documentation of measles immunity should be vaccinated or excluded from the setting. Documentation of vaccination is adequate only if the date of vaccination is provided.
>
> Medical Settings: Routine vaccination -- Medical personnel beginning employment should have documentation of receipt of two doses of measles vaccine after the first birthday unless 1) they were born before 1957 2) have documentation of physician-diagnosed measles, or 3) have laboratory evidence of immunity to measles.
>
> Medical Settings: Outbreak Control -- If an outbreak occurs in areas served by a hospital or within a hospital, ALL employees with direct patient contact who were born in or after 1957, who cannot provide documentation that they received TWO DOSES of measles vaccine on or after their first birthday or other evidence of immunity (see above), should receive a dose of measles vaccine. Since some medical personnel who have acquired measles in medical facilities were born before 1957, vaccination of older employees who may have occupational exposure to measles should by considered during outbreaks. Susceptible personnel who have been exposed should be relieved from direct patient contact from the fifth to the 21st day after exposure regardless of whether they received vaccine or IG after the exposure. Personnel who become ill should be relieved from patient contact for 7 days after they develop rash.

EDUCATION/CONFERENCES

Conferences:

April 28-May 5, 1990: AIDS Awareness Week Activities. For more information, call Bonnie or Karen 523-4775.

June 13-15, 1990: Communicable Disease Interviewing/Field Investigation Course. Cogswell Building, Helena, MT. If you are interested in attending, or wish further information, please call Rhonda Boyle at 444-4740.

Rubella Outbreak in Montana

Seven cases of rubella (German measles) have been recently reported. 6 of the cases have been associated with the Montana State University (M.S.U.) in Bozeman. 1 case was reported in an Anaconda resident. All cases have been in young adults ranging from 20 to 29 years of age.

Five of the cases had a rash onset between March 5th and March 8th. The latest case (as of 4/4/90) is an M.S.U. student with a rash onset of March 29th.

It is likely that other cases may be occurring throughout Montana as many students left the Bozeman area during the period March 12-26.

Suspected rubella cases should be reported, by telephone, immediately to the County Health Department or the Montana Immunization Program at 444-4740.

All persons, regardless of age, should be immune.
Rubella immunity includes documented evidence of:

1) Laboratory results showing immunity or

2) Immunization with rubella vaccine, given in or after 1969 and on or after the first birthday.

Clinical diagnosis of rubella is unreliable and should not be used in considering immune status.

Plan Ahead For The Prevention Of Measles, Mumps And Rubella

The Montana Department of Health and Environmental Sciences recommends all Montana hospitals to implement a mandatory immunization policy for measles and rubella. The Recommendations of the Immunization Advisory Committee should be used. For assistance in this matter, contact the Immunization Program at 444-4740.

All rash illnesses associated with a fever should be reported to the county health departments immediately. Please maintain a high level of suspicion for measles and rubella when persons exhibit a rash illness.

HIV/AIDS INFORMATION

TREATMENT AND RESEARCH

AZT Grant Money

The Montana Department of Health and Environmental Sciences' Acquired Immunodeficiency Disease Syndrome/Sexually Transmitted Disease (AIDS/STD) Program has received a $30,000 grant for the grant year 1990 from the U.S. Department of Health and Human Services for the AIDS Drug Reimbursement Program (ADRP). The money will be used to cover the cost of Azidothymidine (AZT) to prolong and improve the life of a person with Human Immunodeficiency Virus (HIV) Infection or AIDS.

Assistance will be made available to individuals who meet the eligibility requirements which include:

-- a severe economic imbalance
-- being HIV positive or having AIDS
-- physician certification that the patient will benefit from the administration of AZT
-- ineligible for Medicaid
-- utilize any other third party benefits

Priority consideration for enrollment in the Montana ADRP will be given to persons previously enrolled in the program. Enrollment in the program will be limited to the number of participants the program can support with funds available for the grant. Applications will be reviewed and eligibility determined in the order applications are received.

An application form may be requested from the Montana AIDS/STD Program, Department of Health and Environmental Sciences, Cogswell Building, Helena, MT 59620. For questions, contact Andrea Baumgardner, Montana AIDS/STD Program at 444-4740.

Public Health Conference Support Grant Program -HIV Prevention

The Centers for Disease Control announces the availability of funds in Fiscal Year 1990 for the Public Health Conference

Support Grant Program related to Human Immunodeficiency Virus Prevention. Eligible applicants include nonprofit and for-profit organizations. Approximately $225,000 will be available to fund ten awards. The awards will be funded with a 12-month budget and project period. The programmatic areas of interest in which applications are being solicited by CDC for HIV-related conferences are:

(1) Disease prevention;
(2) information/education (specifically regarding the cause and transmission of the virus); and
(3) Biostatistics.

Application deadline is June 1, 1990. A complete program description, information on application procedures and an application package may be obtained from Ms. Carole J. Tully, Grants Management Branch, Procurement and Grants Office, Centers for Disease Control, 225 East Paces Ferry Road, NE., Room 300, Atlanta, GA 30305, (404) 842-6630. Please refer to announcement 017 when requesting information.

Ceftriaxone Not Effective Chlamydia Treatment

Several reports of chlamydia being treated with ceftriaxone have been received by the Montana STD Program in recent months. Although ceftriaxone is listed as the first treatment for gonnorhea in the 1989 Sexually Transmitted Treatment Guidelines issued by the Centers for Disease Control in 9/89, it is not effective against chlamydia.

Dr. Cannon of the STD Division at CDC reported to the STD Program that several studies have been done clinically and in the laboratory which demonstrated that chlamydia does not respond to ceftriaxone. The 1989 CDC recommendations for treatment of Chamydia trachomatis follow:

Treatment of Uncomplicated Urethral, Endocervical, or Rectal C. trachomatis Infections

Recommended regimen - Doxycycline 100 mg orally 2 times a day for 7 days or Tetracycline 500 mg orally 4 times a day for 7 days.

Alternative regimen - Erythromycin base 500 mg orally 4 times a day or equivalent salt for 7 days or Erythromycin ethylsuccinate 800 mg orally 4 times a day for 7 days. If erythromycin is not tolerated because of side effects, the following regimen may be effective: Sulfisoxazole 500 mg orally 4 times a day for 10 days or equivalent.

Treatment of C. trachomatis in Pregnancy

Pregnant women should undergo diagnostic testing for C. trachomatis, N. gonorrhoeae and syphilis, if possible, at their first prenatal visit and, for women at high risk, during the third trimester. Risky factors for chlamydial disease during pregnancy include young age (less than 25 years), past history or presence of other STD, a new sex partner within the preceding 3 months, and multiple sex partners. Ideally, pregnant women with gonorrhea should be treated for chlamydia on the basis of diagnostic studies, but if chlamydial testing is not available, treatment should be given because of the high likelihood of coinfection.

Recommended regimen - Erythromycin base 500 mg orally 4 times a day for 7 days. If this regimen is not tolerated, the following regimens are recommended:

Alternative regimen - Erythromycin base 250 mg orally 4 times a day for 14 days or Erythromycin ethylsuccinate 800 mg orally 4 times a day for 7 days or Erythromycin ethylsuccinate 400 mg orally 4 times a day for 14 days. Alternative if erythromycin cannot be tolerated: Amoxicillin 500 mg orally 3 times a day for 7 days (limited data exist concerning this regimen) or Erythromycin estolate is contraindicated during pregnancy, since drug-related hepatoxicity can result.

Sex Partners of Patients with C. trachomatis Infections

Sex partners of patients who have C. trachomatis infection should be tested and treated for C. trachomatis if their contact was within 30 days of onset of symptoms. If testing is not available, they should be treated with the appropriate antimicrobial regimen.

Five Good Reasons to Report Suspected AIDS Cases

For surveillance of HIV infection and AIDS to be effective, reporting of all suspected cases is necessary. Below is a list of five great reasons to report. If you suspect a case of AIDS to exist, please call your local county health officer or the MDHES AIDS Program at 444-4740.

1) AIDS case reporting is extremely important in monitoring trends in severe HIV-related disease, in modeling trends in HIV infection, and in projecting future numbers of AIDS cases. These data are necessary to plan for future health care needs and services.

2) Trends in AIDS cases provide information on the natural history of HIV infection and help in the development of special studies on HIV infection.

3) Characteristics of AIDS patients are used to direct prevention and educational activities and to evaluate these activities.

4) Reporting of AIDS cases may allow for the identification of persons in need of specific services from State or local health department (e.g., partner notification, counseling, treatments).

5) Numerous agencies, federal and non-federal, utilize AIDS data provided by CDC in developing funding formulas and eligibility criteria for distributing AIDS resources. For example, such agencies as the Health Resources Service Administration (HRSA), the National Institute for Drug Abuse (NIDA), the CDC, and the Robert Wood Johnson Foundation have used surveillance data for awarding millions of dollars to State and local health departments. Such monies have been awarded for:

   -- distributing azidothymidine to indigent AIDS patients
   -- providing hospice care
   -- remodeling buildings to house AIDS patients
   -- establishing intravenous drug use outreach programs
   -- implementing perinatal AIDS prevention programs
   -- developing coordinated services for persons with AIDS in designated cities and states
   -- establishing pediatric AIDS health care demonstration projects
   -- planning activities for out-of-hospital care.

As you can see, AIDS data are widely used and touch many aspects of the HIV epidemic. Hopefully, you can also see how important your contributions are to these activities!

TICK WARNINGS ADVISED

Late spring and summer are peak times for tick exposure in Montana. It is hereby requested that warnings be issued via the local media concerning risks to health from tick exposure. Over 90% of cases of Rocky Mountain Spotted Fever (RMSF) occur between April 1st and September 30th.

Some illnesses for which Montana ticks have been shown to be vectors include RMSF, Colorado Tick Fever and tularemia. There is no evidence that ticks in Montana transmit Lyme disease or that tick species indigenous to Montana are competent vectors of Borrelia burgdorferi, the causative agent.

Tick Precautions

Avoid tick infested areas.

Apply repellant such as diethltholuamide (DEET) to clothing. (See "Repellant Precautions" below)

Wear clothing that interferes with tick attachment; long sleeves, high boots, sleeves that are tight around the wrist, pant legs which are gathered around the ankle.

During and after visits to heavily infested areas, a person should check for ticks at least every four hours. Ticks not allowed to attach to a person will not transmit disease.

Carefully inspect ears, underarms, body folds and around hairlines.

Ticks should be removed in a manner which removes the entire tick but does not crush them or allow the secretions from the tick

to contaminate the person removing them. Mechanical removal is recommended.

Tick Removal Procedure

1. DISINFECT THE SITE prior to tick removal.

2. GRASP THE TICK AS CLOSE TO THE SKIN AS POSSIBLE using a blunt curved forceps or tweezers.

3. PULL UPWARD WITH A STEADY EVEN PRESSURE. Do not twist or jerk as this may cause the mouthparts to break off leaving them and the cement collar in the skin.

4. TAKE CARE NOT TO SQUEEZE, CRUSH, OR PUNCTURE THE BODY OF THE TICK as its fluids may contain infective agents. After removing the tick, thoroughly DISINFECT THE BITE SITE and WASH HANDS WITH SOAP AND WATER.

5. APPLY A STERILE ADHESIVE DRESSING STRIP (band-aid type) to prevent secondary infection. TICKS CAN BE SAFELY DISPOSED OF by placing them in a container of alcohol or by flushing them down the toilet.

The various "traditional" methods have all failed to show effectiveness and forcible removal remains the method of choice. Removal should be timely. Undamaged ticks can be submitted for identification.

Repellent Precautions

Recent anecdotal reports of adverse effects of DEET have heightened public awareness but appropriate evaluation of other etiologies is lacking. According to MMWR, repellents containing 20-30% DEET applied to clothing are approximately 90% as effective as dermal application in preventing tick attachment.

DEET has been marketed in the United States since 1956 and is used by an estimated 50-100 million persons each year. It is partially absorbed through the skin. To minimize the possibility of adverse reactions to DEET, the following precautions are suggested:

*Apply repellent sparingly only to exposed skin or clothing.

*Avoid applying high-concentration products to the skin, particularly of children.

*Do not inhale or ingest repellents or get them into the eyes.

*Wear long sleeves and long pants, when possible, and apply repellent to clothing to reduce exposure to DEET.

*Avoid applying repellents to portions of children's hands that are likely to have contact with eyes or mouth.

*Never use repellents on wounds or irritated skin.

*Use repellent sparingly; one application will last 4-8 hours. Saturation does not increase efficacy.

*Wash repellent-treated skin after coming indoors.

For further information, contact the Montana Department of Health at 444-4740. RMSF, Colorado tick fever, Q fever and tularemia are reportable diseases - please notify the Department of any such illnesses.

Group A Streptococcus Fatality

A three year old girl was seen in the emergency room of a local hospital; she died within minutes of arrival. Results of cultures performed on spinal fluid, pleural fluid, and blood revealed Group A Streptococcus at all sites. Disease prodrome consisted of nonspecific upper respiratory symptoms for four days. It is unknown at this time if the patient had underlying disease or malfunction which may have predisposed her to this infection. Further testing is currently being conducted to determine if this fatality was caused by an unusual strain of Group A Streptococcus which researchers have labeled "toxigenic". Toxic Streptococcal syndrome has been reported to be characterized by renal failure, acute respiratory distress syndrome, shock, and death. Disease severity seems to be correlated with the production of the bacterial virulence factor, pyrogenic exotoxin A, which is produced by some strains of Group A Streptococcus. The majority of victims reported have been elderly men with a prodromal Group A Streptoccus cellulitis. The organism isolated in this case has been referred to a Streptococcal reference laboratory to

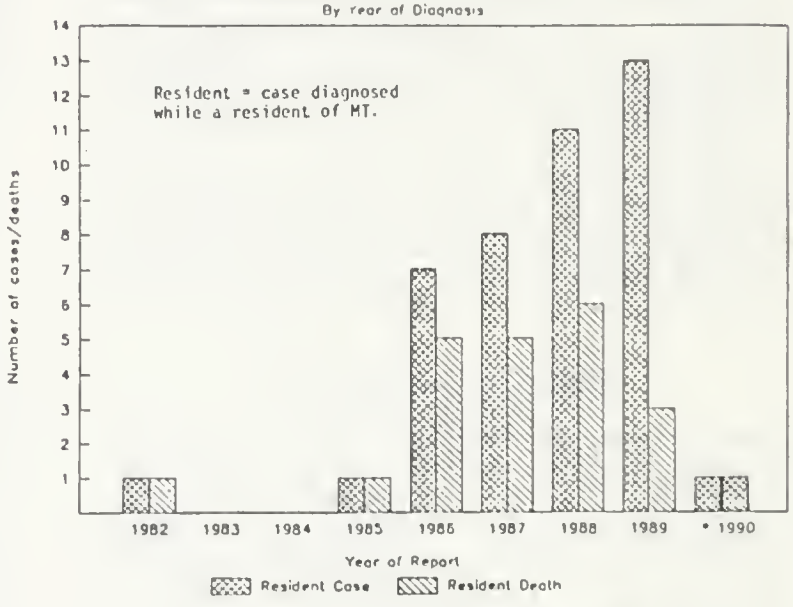
determine if it produces the specific toxin implicated in this disease syndrome.

The Montana Department of Health and Environmental Sciences (DHES) is participating in a research project examining risk factors associated with the toxic streptococcal syndrome. Since cases of toxic Group A Streptococcus infections were reported beginning in 1987, it is postulated that virulent strains have begun to reappear, possibly due to lack of antibody protection in the general population. The purpose of the project is to examine the prevalence and pathogenic characteristics of Group A Streptococcus in the Rocky Mountain area (including in healthy individuals), to examine the virulence factor profiles of isolates from clinical cases and determine if an association exists between specific virulence factors and clinical syndromes, and to determine the effect of anti-toxin antibody on the outcome of disease.

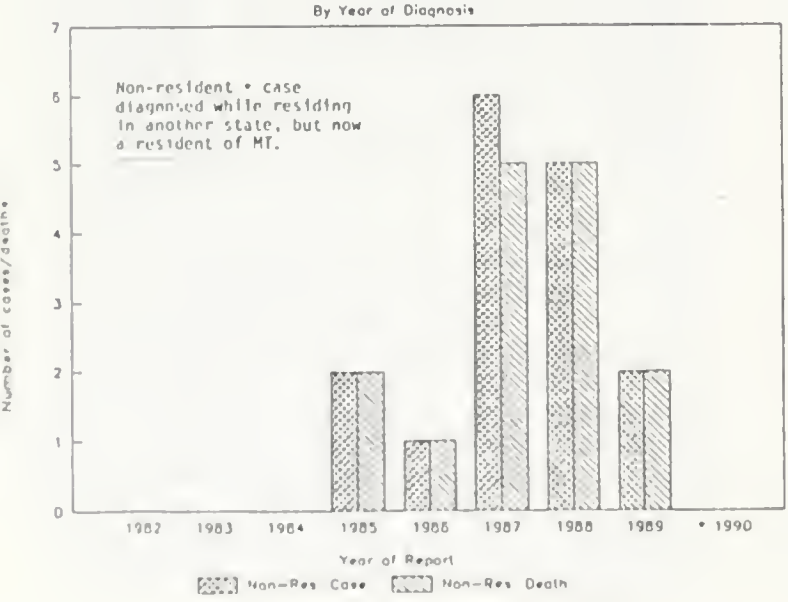
DHES will supply personnel and materials to collect specimens (cultures and blood) and epidemiological data for sites in Montana that may have a number of cases of Group A Streptococcus. We would also like to collect specimens from healthy individuals from all age groups. Please notify DHES if you know of a case that clinically fits the toxic syndrome described. If you have further questions or suggestions for study sites, please contact Anne Weber at the Public Health Laboratory (444-2642).

At this time there is no recommendation that the standard practices in diagnosis, treatment, and follow-up of Group A Streptococcal infections be changed.

Montana Resident AIDS Case and Death



MT Non-Resident AIDS Case and Death



Source: Montana Department of Health and Environmental Sciences, AIDS/STD Program, March 31, 1990.

* 1990 numbers are through March 31, 1990.

MARCH 1990	Campylobacter, diarrhea	Chlamydia, sexually-trans.	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatmt	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead		2													
Big Horn		3												2	
Blaine							1		1						
Broadwater															
Carbon															
Carter															
Cascade		14	1												
Chouteau															
Custer		2		1											
Daniels															
Dawson		1													
Deer Lodge			1				2				2				
Fallon															
Fergus			5												
Flathead		4	6	1		1	3	1					1		
Gallatin	1	23		3									1		
Garfield															
Glacier		10		1		1	1		1				1		
Golden Valley															
Granite			1												
Hill		2	1												1
Jefferson															
Judith Basin												1			
Lake		8		2		3									
Lewis & Clark		12	2				1						1		
Liberty															
Lincoln		1													
McCone															
Madison			1												
Meagher															
Mineral															
Missoula		11				1	2			1				4	
Musselshell															
Park		2			1								1		
Petroleum															
Phillips															
Pondera															
Powder River															
Powell													1		
Prairie															
Ravalli															
Richland															
Roosevelt		7												7	1
Rosebud		1		1		2									2
Sanders				1											
Sheridan															
Silver Bow	2	12	1	1									3		
Stillwater	1														
Sweet Gress			1									1			
Teton															
Toole															
Treasure															
Valley	1	1													
Wheatland															
Wibaux															
Yellowstone		20	3	3			1							1	
MONTHLY TOTAL 19 90	5	136	23	14	1	8	11	1	2	1	2	2	9	14	4
MONTHLY TOTAL 19 89	0	128	9	13	0	4	3	0	0	1	5	8	5	13	4
MONTHLY TOTAL 19 88	2	168	11	37	1	2	5	2	0	0	3	29	5	3	0
TOTAL TO DATE 19 90	7	395	42	43	4	26	26	2	3	4	19	9	19	19	4
TOTAL TO DATE 19 89	7	376	24	58	1	12	15	1	0	1	15	20	19	48	4
TOTAL TO DATE 19 88	7	568	44	106	4	16	15	3	2	0	19	63	13	15	0

OTHER DISEASES: Bacterial Meningitis Unspecified:Gallatin-1 Missoula-1 Chickenpox:Cascade-1,Gallatin-4,Hill-5,Lake-10, Lewis & Clark-3 Rubella:Deerlodge-1,Gallatin-4 Measles(IMP) Lewis & Clark-1 Cytomegalo-viral Illness: Cascade-1 Listeriosis: Deerlodge-2

DELAYED REPORTS:

MONTANA DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES

*MONTANA
RESIDENT AND NON-RESIDENT AIDS CASES
Acquired Immunodeficiency Syndrome (AIDS)
Definitive and Presumptive AIDS Cases
Surveillance Report - 3/1/90 to 3/31/90

1. Disease Category

	Adult/Adolescent Cases (%)	Deaths (%)
PCP	29 (50)	19 (33)
Other Disease w/o PCP	26 (45)	18 (31)
KS Alone	3 (5)	0 (0)
No Diseases Listed	0 (0)	0 (0)
Total	58 (100)	37 (64)

2. Age

Age	Cases (%)
Under 13	0 (0)
13-19	0 (0)
20-29	18 (31)
30-39	26 (45)
40-49	9 (16)
Over 49	5 (9)
Unknown	0 (0)
Total	58 (100)

3. Race/Ethnicity

	Adult/Adolescent Cases (%)
White, Not Hispanic	53 (91)
Black, Not Hispanic	1 (2)
Hispanic	2 (3)
Native American	2 (3)
Unknown	0 (0)
Total	58 (100)

4. Exposure Category

	Adult/Adolescent Males (%)	Females (%)	Total (%)
Homosexual or Bisexual Men	35 (61)	0 (0)	35 (59)
Intravenous (IV) Drug User	6 (10)	0 (0)	6 (11)
Homo/Bi IV Drug User	6 (10)	0 (0)	6 (11)
Hemophiliac	3 (5)	0 (0)	3 (5)
Heterosexual Contact	0 (0)	4 (7)	4 (7)
Transfusion With Blood/ Products	0 (0)	0 (0)	0 (0)
None of the Above/Other	3 (5)	1 (2)	4 (7)
Total	53 (91)	5 (9)	58 (100)

Source: Montana AIDS/STD Program, MDHES, through March 31, 1990.

*Includes 42 Montana AIDS cases and 16 cases reported to Centers for Disease Control from other states who are living in Montana.

As of March 31, 1990 there have been 250 positive HIV tests from 19,744 tests conducted through the MDHES Public Health Laboratory.

Nationally, as of February 28, 1990, 124,984 cases of AIDS and 76,030 deaths have been reported to the Centers for Disease Control.

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Volume: 14-3 Month of: MARCH 1990

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VOLUME 14-4 APRIL 1990

Montana State Department of Health and Environmental Sciences

* *
* HIV/AIDS INFORMATION *
* *

EDUCATION/CONFERENCES

Class Offering

June 13-15, 1990: "Communicable Disease Interviewing/Field Investigation Course," Helena, Montana. For more information call Rhonda (Boyle) Forrette at 444-2675.

CORRECTION FOR THE 1989 ANNUAL SUMMARY REPORT

Inadvertently, the total number of AIDS cases for 1989 was left off the Annual Summary Report. The total number of reported AIDS cases for 1989 was 15. Please make this correction on the Annual Summary Report.

AIDS/STD Program Staff Changes

Andrea Baumgardner, R.N., B.S.N. has been offered and accepted the position of Program Officer I of the Montana AIDS/STD Program. This position will focus mostly on surveillance of AIDS and STDs. A main emphasis for this position will be to improve AIDS case reporting in Montana. If anyone has any suggestions or comments for AIDS case reporting, please call or write Andrea at 444-4740 or during her maternity leave (June - August), please call Bruce Desonia at the same number.

TREATMENT AND RESEARCH

AIDS: A Personal Responsibility - Video of A Montanan With AIDS

The AIDS Program of the Montana Department of Health and Environmental Sciences (MDHES) has copies of a video filmed recently by a Montana person with AIDS (PWA). The video was produced under contract with MDHES and the Montana Office of Public Instruction. The documentary style film features a PWA who was extremely active in delivering the message of AIDS prevention in our state and other western states. He was also very active in AIDS support services organization on a local and statewide level.

He tells his story in a very candid and personal way. The title of the film, AIDS: A Personal Responsibility, reflects his attitude toward the disease. His work in his hometown and around Montana in the last year and a half of his life reflect his own sense of responsibility. The film is powerful in the human story he tells with no self-pity or blame. The video was produced for general audience viewing. It is an excellent resource for high school and college audiences, who still believe that, "It can't happen to me." It did happen to this young man and he made AIDS education a priority for his life. This is his story.

The 17-minute video is available for loan from one of the eleven HIV antibody (AIDS virus) counseling and testing sites around the state or contact the MDHES AIDS Program (444-4740). Written requests may also be sent to:

MDHES AIDS Program
Cogswell Building
Helena MT 59620

WHAT'S HAPPENING IN YOUR COMMUNITY?

Rural IV Program Outreach
By Greg Oliver and Mary Birch

Most AIDS prevention programs for IV drug users have targeted urban communities. Rural communities like those in Montana have been largely ignored. We know these communities differ from urban areas in low density population and low visibility of IV drug use but our knowledge of the prevalence and the drug use patterns among rural IVDUs is quite limited. Do these IVDUs have personal profiles similar to those in urban areas? Are the type of drugs injected and the patterns of drug use similar? How can this population be identified and contacted? Will the rural IVDU respond to AIDS risk reduction information as urban IVDUs have?

The MDHES AIDS Program is funding a Missoula AIDS Council proposal to contact the rural IV drug using population for answers to these questions and to provide AIDS risk reduction information and supplies. Currently 22 percent of the AIDS cases in Montana are associated with IV drug use. To intervene at this time will help to reduce further spread of the virus to other IVDUs and to curb the secondary spread of AIDS to their sexual partners.

The purpose of this project is to identify effective ways of contacting and educating intravenous drug users in rural communities about AIDS and to reduce the spread of AIDS among these rural IVDUs and their sexual partners by providing AIDS risk reduction information and supplies. Although the number of IVDUs in Montana is not known, a recent study by the Montana State Health Department found that 72 percent of 233 IVDUs who responded to questionnaires had shared needles to inject drugs and 69 percent did not use condoms during sexual intercourse. These behaviors are the primary means by which the AIDS virus is spread among IVDUs and their sexual partners. Currently there are no outreach programs in Montana aimed at the reduction of these high risk behaviors among IVDUs.

This project will adapt the program developed by the San Francisco Mid-City Consortium to Combat AIDS to the rural environments of Montana. The San Francisco program has been successful in getting IVDUs to modify their high risk behavior of sharing contaminated needles. The central feature of this program has been the hiring of community health outreach workers -- called CHOWS -- to make contact with this traditionally hard-to-reach group to encourage the IV drug user to clean their needles before sharing them and to use condoms during sexual intercourse. The CHOWS are paid supervised streetwise individuals, often ex-addicts, who locate IVDUs not in treatment and provide education on AIDS risk reduction. They also distribute condoms and bottles of bleach for cleaning needles and syringes.

In a survey completed by the San Francisco Urban Health Study (1986-88), IVDUs reported using safe needle hygiene 68 percent of the time in targeted areas after contact by the CHOWS, whereas only 13 percent had previously used safe hygiene. Overall the study demonstrated a significant impact on IVDU risk behavior and post intervention data showed "(a) reduction in the number of sharing partners; (b) increased use of condoms; (c) reduction in the frequency of using previously used injection equipment; and (d) continued increase in the use of safe needle hygiene." Success in utilization of safe sex methods was not as dramatic as needle hygiene. Researchers noted that "this area of behavior change will continue to present a major challenge over the coming years" and concluded that this "underscores the need to intervene quickly with IVDUs regarding needle hygiene in order to prevent infection from taking hold in a population of heterosexual IVDUs and leading to secondary transmission to non-IV drug using partners."

The proposed project will model the San Francisco project by hiring two part-time community outreach workers, former IVDUs, who will be trained in understanding the transmission of the AIDS virus and preventive behaviors. These outreach workers will contact IVDUs from their own circle of present and former acquaintances to begin the educational program. Through these contacts additional contacts will be identified and the outreach effort will expand. Two part-time community outreach workers will be hired in order to maximize the number of IVDUs initially contacted, assuming each worker will have a separate group of IVDU acquaintances to begin the initial contact.

In the process of making contacts the outreach workers will gather information on the risk behavior of the IV drug user, on

the most effective way to make contact with the IVDUs to reduce apprehension and promote receptivity, and on effective ways to deliver the risk-reduction recommendations and to encourage compliance with these recommendations.

In addition the outreach worker will conduct follow-up contacts wherever possible and keep accurate confidential records of all contacts for use in evaluating the success of the project. The records will be destroyed once the needed data is processed.

It is anticipated that the rural CHOWS will contact approximately 200 IVDUs in target areas, including Missoula, Butte and Helena. In addition to direct contact with known IV drug users, the community outreach worker will contact community organizations such as Narcotics Anonymous, drug treatment programs and AIDS testing centers to increase the number of IVDU contacts and to coordinate efforts with the goals and activities of these community organizations. A final report will be prepared at the end of the project and recommendations will be made on how to maximize outreach efforts in rural communities and this will be disseminated to appropriate state and community agencies.

(Greg Oliver is the Director of Health Education at Missoula City-County Health Department and Mary Birch is a Social Work Professor at the University of Montana.)

TREATMENT AND RESEARCH

Risk Behaviors for HIV Transmission Among Intravenous Drug Users Not in Drug Treatment -- United States, 1987-1989

A major limitation to preventing transmission of human immunodeficiency virus (HIV) among intravenous drug users (IVDUs) has been that most information about IVDUs' drug use and sexual behavior has been derived from studies of the most accessible subgroup (i.e., persons in drug treatment programs) and therefore may not be representative of all IVDUs. Such data have been particularly limited for IVDUs not in drug treatment. This report provides preliminary data from September 1987 through December 1989 about IVDUs not in drug treatment programs. The data are derived from the National AIDS Outreach Demonstration Research Project, which was initiated in 1987 by the National Institute on Drug Abuse (NIDA) and directed at IVDUs not in drug treatment programs and their sex partners.

Objectives of the NIDA project included 1) collection of information on drug use and sexual behaviors of IVDUs not in treatment, 2) assessment of knowledge about HIV transmission and acquired immunodeficiency syndrome (AIDS) among IVDUs and their sex partners, and 3) communication of information regarding HIV transmission and AIDS to IVDUs and their sex partners.

From September 1987 to October 1988, outreach demonstration programs were established in 63 sites in 45 cities in the United States and Puerto Rico. IVDUs were recruited from hospital emergency rooms and inpatient settings, jails and prisons, public housing projects, community-based organizations, sexually transmitted disease clinics, and neighborhoods frequented by IVDUs.

Persons recruited for the program must have injected drugs during the 6 months before recruitment and not have been enrolled in a formal drug treatment program during the 30 days before the intake interview. At recruitment and at 6-month follow-up intervals, trained interviewers used a standardized questionnaire to collect detailed information from participants about knowledge and behaviors related to drug use and sexual activity.

For 16,998 IVDUs not in treatment, preliminary data were obtained on their geographic distribution, demographics, employment status, drug use, and sexual activity. Of these, 5,091 (30%) were recruited in the Northeast, 5,028 (30%) in the Southeast, 4,017 (24%) in the West, 2,135 (13%) in the Midwest, and 727 (4%) in Puerto Rico.

Of the 16,998 IVDUs for whom data were obtained, 13,595 (80%) were between the ages of 25 and 44 years; 12,678 (75%) were male; 8,585 (51%) were black, and 4,498 (26%) were Hispanic; 9,077 (53%) were unemployed, and 2,620 (15%) worked occasionally; and 6,722 (40% had never been in drug treatment. In addition, 14,067 (83%) reported having been in jail or prison at some time; of these, 11,392 (81%) had never participated in formal drug treatment while incarcerated.

MONTANA DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES

MONTANA
RESIDENT AND NON-RESIDENT AIDS CASES*
Acquired Immunodeficiency Syndrome (AIDS)
Definitive and Presumptive AIDS Cases
Surveillance Report - 4/1/90 to 4/30/90

1.

Disease Category	Adult/Adolescent Cases (%)	Deaths (%)
PCP	29 (50)	19 (33)
Other Disease w/o PCP	26 (45)	18 (31)
KS Alone	3 (5)	0 (0)
No Diseases Listed	0 (0)	0 (0)
Total	58 (100)	37 (64)

2.

Age	Cases (%)
Under 13	0 (0)
13-19	0 (0)
20-29	18 (31)
30-39	26 (45)
40-49	9 (16)
Over 49	5 (9)
Unknown	0 (0)
Total	58 (100)

3.

Race/Ethnicity	Adult/Adolescent Cases (%)
White, Not Hispanic	53 (91)
Black, Not Hispanic	1 (2)
Hispanic	2 (3)
Native American	2 (3)
Unknown	0 (0)
Total	58 (100)

4.

Exposure Category	Adult/Adolescent Males (%)	Females (%)	Total (%)
Homosexual or Bisexual Men	35 (61)	0 (0)	35 (59)
Intravenous (IV) Drug User	6 (10)	0 (0)	6 (11)
Homo/Bi IV Drug User	6 (10)	0 (0)	6 (11)
Hemophiliac	3 (5)	0 (0)	3 (5)
Heterosexual Contact	0 (0)	4 (7)	4 (7)
Transfusion With Blood/ Products	0 (0)	0 (0)	0 (0)
None of the Above/Other	3 (5)	1 (2)	4 (7)
Total	53 (91)	5 (9)	58 (100)

Source: Montana AIDS/STD Program, MDHES, through April 30, 1990.

*Includes 42 Montana AIDS cases and 16 cases reported to Centers for Disease Control from other states who are living in Montana.

As of April 30, 1990 there have been 253 positive HIV tests from 20,195 tests conducted through the MDHES Public Health Laboratory.

Nationally, as of March 31, 1990, 128,319 cases of AIDS and 78,340 deaths have been reported to the Centers for Disease Control.

During the 6 months before the intake interview, 16,712 (98%) of IVDUs had injected cocaine or heroin either alone, sequentially, or mixed; 5,824 (34%) predominantly injected heroin, 5,310 (31%) predominantly injected cocaine, and 5,578 (33%) predominantly injected combinations of heroin and cocaine. Two hundred eighty-six (2%) reported injecting amphetamines or other drugs but not heroin or cocaine. Ten thousand seventy-seven (59%) reported injecting drugs daily. In addition, 13,249 (78%) IVDUs reported sharing drug injection equipment with another IVDU, and 3,454 (20%) reported sharing with strangers.

Twenty percent of IVDUs reported always using new injection equipment. Of those sharing equipment, 14% always cleaned the equipment with bleach before injecting. Sixty percent of IVDUs who reused drug injection equipment cleaned the equipment with bleach at least some of the time.

In general, IVDUs reported "never using" a condom during sexual activity, although the prevalence of condom use varied by type of sexual activity. Almost half of both male and female IVDUs reported having two or more sex partners during the six months before recruitment.

(From the MMWR, Vol. 39, No. 16, April 27, 1990)

Notice: The MDHES AIDS Program is missing all copies of a video, "AIDS: A Preventable Epidemic" produced by Oregon Health Division. If you have copies of this video in your holdings, please check them for MDHES AIDS Program stickers. If you have any questions, please call Beth Smith Mitchell at 444-4740. Thank you.

T.B. Elimination Plan

In 1987, the Secretary of the U.S. Department of Health and Human Services established a committee for elimination of tuberculosis. The following is an excerpt from the April 27, 1989, Morbidity and Mortality Weekly Report, regarding a stategic plan for the elimination of tuberculosis in the United States.

> Improving case prevention. Preventable tuberculosis cases continue to occur in the United States. By definition, preventable cases include all those for whom one or more of the currently recommended interventions should have been utilized, but were not. These interventions include contact identification and examination, preventative therapy for infection, diagnosis of disease, prompt reporting, isolation of persons with suspected and diagnosed tuberculosis, adequate ventilation of buildings, the use of ultra-violet lights in high risk areas of buildings, chemo-therapy for disease, and directly observed therapy. Some of these interventions (e.g., isolation) are designed to prevent transmission of infection among residents and staff of high risk institutions such as hospitals, nursing homes, correctional institutions, and shelters for the homeless. Other interventions (e.g., preventive therapy) are designed to prevent disease among those already infected. High risk preventive therapy reduces the risk of tuberculosis by more than 90% among persons who complete a full course of treatment.
>
> To prevent infection among persons potentially exposed to an infectious case of tuberculosis and to prevent tuberculosis among contacts and other infected persons for whom preventive therapy is recommended, the following methods should be implemented by January 1, 1991. 1) All U.S. residents should have the results of at least one tuberculin skin test in their medical records, and those whose test result is positive should be evaluated and counseled regarding the risk of developing tuberculosis. 2) Each health department should assess the prevelance, instance and socio-demographic character of infected persons in the community. 3) Tuberculin skin testing programs should be conducted annually among the staffs of tuberculosis clinics, mycyobacteriology laboratories, shelters for the homeless, nursing homes, substance abuse treatment centers, dialysis units and correctional institutions. The staffs of hospitals, mental institutions, and home health care agencies should be tested annually if the prevalence of infection exceed 5%. 4) Consideration should be given to installing and properly maintaining ultra violet lights in high risk facilities, such as jails, prisons and shelters for the homeless. 5) Hospitals that admit untreated tuberculosis patients or persons suspected of having tuberculosis should have proper facilities and procedures for instituting respiratory isolation. 6) Consideration should be given to routinely obtaining sputum from microbacterial smear cultures from symptomatic nursing home residents thought to have a low respiratory infection.

The six items listed above are from a group of 17. The other recommendations will be discussed in following issues of the Montana Morbidity report. Several comments can be made regarding the six items in this edition. Montana has a requirement for testing of health care facility workers. It is also known tuberculosis cases are often patients in health care facilities for extended periods before diagnosis of tuberculosis is made. Therefore, the need for continued testing of health care facility workers must be maintained until better data is available.

* * * * * * * * * *

The Communicable Disease Section is interested in sharing with Montana Morbidity Report readers activities, projects and studies occurring within our state. Starting with this issue, you will see a new section in the Report called "What's Happening In Your Community?" Our first contribution is from the Missoula City-County Health Department.

You are encouraged to contribute to this section. Please direct materials and/or questions to: Rhonda Forrette, Communicable Disease Section, Cogswell Building, Helena, MT 59601. Phone: 444-2675.

* * * * * * * * * *

APRIL 1990	Campylobacter, diarrhea	Chlamydia, sexually transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non A, Non B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead	1	1	1												
Big Horn		6		3		1				1					
Blaine		3					1								
Broadwater															
Carbon															
Carter															
Cascade		12	1	1							1				
Chouteau															
Custer		2		1							1				
Daniels															
Dawson															
Deer Lodge		3		1											
Fallon															
Fergus	1	4													
Flathead		1				1					1		1		
Gallatin		9				1					1		1		
Garfield															
Glacier		3				1	1								
Golden Valley															
Granite															
Hill		9													
Jefferson		1		3											1
Judith Basin															
Lake		7		3		2									
Lewis & Clark		8	1			1				1					
Liberty															
Lincoln		1													
McCone															
Madison	1	1													
Meagher															
Mineral															
Missoula	4	11	1			1	2						3	2	
Musselshell															
Park															
Petroleum															
Phillips															
Pondera		2										1			
Powder River												1			
Powell	1														1
Prairie															
Ravalli		2													
Richland															
Roosevelt		3		4									1		1
Rosebud		1				2									2
Sanders						1									
Sheridan															
Silver Bow		12		1									1		
Stillwater															
Sweet Grass												1			
Teton											1	3			
Toole															
Treasure															
Valley		1		1											
Wheatland	1														
Wibaux															
Yellowstone		33		2		1							1		
MONTHLY TOTAL 1990	9	136	4	20	0	12	4	0	0	1	5	6	8	2	6
MONTHLY TOTAL 1989	4	128	8	23	1	3	1	0	0	0	7	6	2	10	1
MONTHLY TOTAL 1988	4	134	4	52	0	1	5	1	0	0	6	27	7	5	0
TOTAL TO DATE 1990	16	272	27	34	1	20	15	1	2	1	12	12	10	12	7
TOTAL TO DATE 1989	11	504	32	81	2	15	16	1	0	1	22	26	21	58	5
TOTAL TO DATE 1988	11	702	48	158	4	17	20	4	3	0	25	90	20	20	0

OTHER DISEASES: Bacterial Meningitis Unspecified: Galatin-2 Chickenpox: Cascade-9, Wheatland-1, Yellowstone-2 Colorado Tick Fever: Missoula-1 Cytomegal-viral Illness: Cascade-1, Yellowstone-1 Rubella: Big Horn-1, Gallatin-6, Phillips-1

Announcing
COMMUNICABLE DISEASE INTERVIEWING/
FIELD INVESTIGATION COURSE
June 13-15, 1990
Billings, Montana

The above course, held in Billings in May of 1989, will be repeated in Helena, starting at 11:00 a.m. on June 13 and concluding at 11:00 a.m. on June 15. The course is intended for local public health agency professionals, but is open to others interested.

It has been submitted for CEARP through the Montana Nurses' Association. There will be no registration fee for the course. Those interested in attending are asked to send their name, address and agency affiliation to Rhonda (Boyle) Forrette, Montana Department of Health and Environmental Sciences, Communicable Disease Section, Cogswell Building, Helena, MT 59620, or call at 444-2675. Further information will be sent to the registrants about location, agenda, etc.

Following is an outline of the course with allotted hours:

Wednesday, June 13, 1990

Hours

.75 - Statutes, Rules, Confidentiality
1.0 - Communicable Disease Theory
.75 - Public Health Lab Services
1.25 - When to Begin an Investigation, Case Management and Forms

Thursday, June 14, 1990

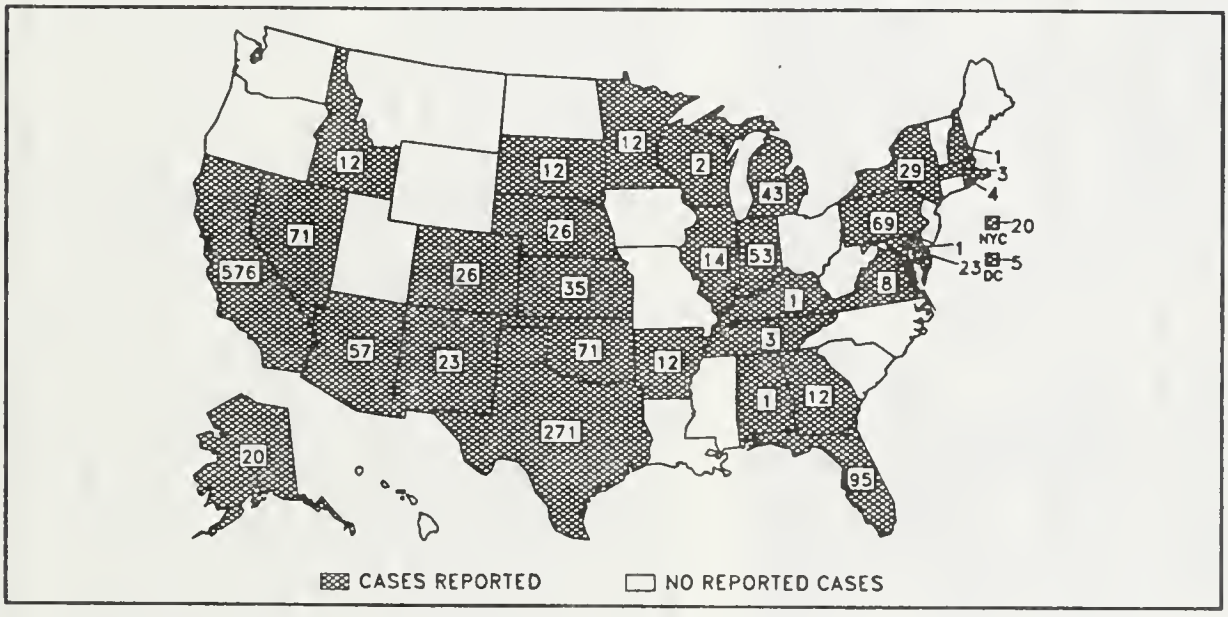
.5 - Communication
1.25 - Interview/Counseling Format
.5 - Cluster Interviewing
1.0 - Interview Video and Discussion
2.25 - Application of Interview Skills
1.0 - Principles of Field Investigation

Friday, June 15, 1990

.75 - Field Investigation (continued)
1.5 - Video and Application of Field Investigation Principles

12.5 hours

Reported cases of measles, by state — United States, weeks 14–17, 1990



Supplementary Statement: Change in Administration Schedule for Haemophilus b Conjugate Vaccines

In December 1989, the Food and Drug Administration licensed a new vaccine—Haemophilus b Conjugate Vaccine (Meningococcal Protein Conjugate) (PRP-OMP)—for routine use in children ≥18 months of age. The license contains the statement that PRP-OMP can be given to children as young as 15 months of age when "it is expected that the child will not return at 18 months of age for Haemophilus b immunization." Since December 1989, two vaccines previously licensed for use in children at 18 months of age—Haemophilus b Conjugate Vaccine (Diphtheria Toxoid Conjugate) (PRP-D) and Haemophilus b Conjugate Vaccine (Diphtheria CRM_{197} Protein Conjugate) (PRP-HbOC)—also have been approved for use in children as young as 15 months of age.

Some differences in immunogenicity may exist among different Haemophilus b conjugate vaccines (*1*). However, further studies are needed to confirm any differences and evaluate their clinical relevance. In addition, immunogenicity is age-dependent, with immune response improving with increasing age (Table 1).

Approximately 7% of all *Haemophilus influenzae* type b disease in children <5 years of age occurs in children 15–17 months of age. Because of the substantial immunogenicity of the Haemophilus b conjugate vaccines when given to children in this age group, the Immunization Practices Advisory Committee (ACIP) now recommends routine vaccination of children at 15 months instead of at 18 months of age using any of the Haemophilus b conjugate vaccines licensed for use. Prior ACIP recommendations for the use of PRP-D are applicable to the newer conjugate vaccines (*2*).

References

1. Wenger JD, Ward JI, Broome CV. Prevention of *Haemophilus influenzae* type b disease: vaccines and passive prophylaxis. In: Remington JS, Swartz MN, eds. Current clinical topics in infectious diseases. Vol 10. Boston: Blackwell Scientific Publications, 1989:306–39.
2. ACIP. Update: prevention of *Haemophilus influenzae* type b disease. MMWR 1988;37:13–6.

TABLE 1. Haemophilus b conjugate vaccines: differences in immunogenicity by age of child at vaccination*

Vaccine	Children 15–17 mos.			Children 18–23 mos.		
	No.	% >1 µg/mL†	GMT§	No.	% >1 µg/mL†	GMT§
PRP-D¶	43	53**	1.2	180	73**	3.1
PRP-HbOC††	236	98§§	10.8	141	97§§	12.3
PRP-OMP¶¶	71	80**	3.3	84	97**	7.2

*Because of interlaboratory variability in assays for antibody to the capsular polysaccharide of *Haemophilus influenzae* type b (PRP), definitive comparisons between vaccines cannot be made based on these data.
†Percentage of children with >1 µg/mL PRP antibody 4–8 weeks after vaccination.
§Geometric mean titer of PRP antibody (µg/mL).
¶Haemophilus b Conjugate Vaccine (Diphtheria Toxoid Conjugate). Source: Connaught Laboratories, Inc., unpublished data
**$p<0.05$ (15–17 months vs. 18–23 months). PRP-D data for "children 18–23 mos" column are from children 18–24 months at vaccination.
††Haemophilus b Conjugate Vaccine (Diphtheria CRM_{197} Protein Conjugate). Source: Praxis Biologics, unpublished data.
§§Not significant (15–17 months vs. 18–23 months).
¶¶Haemophilus b Conjugate Vaccine (Meningococcal Protein Conjugate). Source: Merck Sharp and Dohme, unpublished data

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Montana State Department of Health and Environmental Sciences

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Lyme Disease National Surveillance Case Definition

Lyme disease is a systemic tick-borne disease with protean manifestations, including dermatologic, rheumatic, neurologic and cardiac abnormalities. The best clinical marker for the disease is the initial skin lesion, erythema migrans (EM) that occurs in 60% to 80% of patients.

Case Definition for National Surveillance of Lyme Disease

A case of Lyme disease is defined as follows:

1. A person with erythema migrans;

2. A person with at least one late manifestation and laboratory confirmation of infection.

General definitions:

1. Erythema migrans (EM): For purposes of surveillance, EM is a skin lesion that typically begins as a red macule or papule and expands over a period of days or weeks to form a large round lesion, often with a partial central clearing. A solitary lesion must reach at least 5 cm in size. Secondary lesions may also occur. Annular erythematous lesions occurring within several hours of a tick bite represent hypersensitivity reactions and do not qualify as EM. In most patients, the expanding EM lesion is accompanied by other acute symptoms, particularly fatigue, fever, headache, mild stiff neck, arthralgias or myalgias. These symptoms are typically intermittent. The diagnosis of EM must be made by a physician. Laboratory confirmation is recommended for persons with no known exposure.

2. Late manifestations: These include any of the following when an alternative explanation is not found.

   a. Musculoskeletal system: Recurrent, brief attacks (weeks or months) of objective joint swelling on one or a few joints sometimes followed by chronic arthritis in one or a few joints. Manifestations not considered as criteria for diagnosis include chronic progressive arthritis not preceded by brief attacks and chronic symmetrical polyarthritis. Additionally, arthralgias, myalgias or fibromyalgia syndromes alone are not accepted as criteria for musculoskeletal involvement.

   b. Nervous system: Lymphocytic meningitis, cranial neuritis, particularly facial palsy (,may be bilateral), radiculoneuropathy or rarely, encephalomyelitis alone or in combination. Encephalomyelitis must be confirmed by showing antibody production against B. burgdorferi in the cerebrospinal fluid (CSF), demonstrated by a higher titer or antibody in CSF then in serum. Headache, fatigue, paresthesias, or mild stiff neck

alone are not accepted as criteria for neurologic involvement.

c. Cardiovascular system: Acute onset, high grade (2nd or 3rd degree) atrioventricular conduction defects that resolve in days to weeks and are sometime associated with myocarditis. Palpitations, bradycardia, bundle branch block or myocarditis alone are not accepted as criteria for cardiovascular involvement.

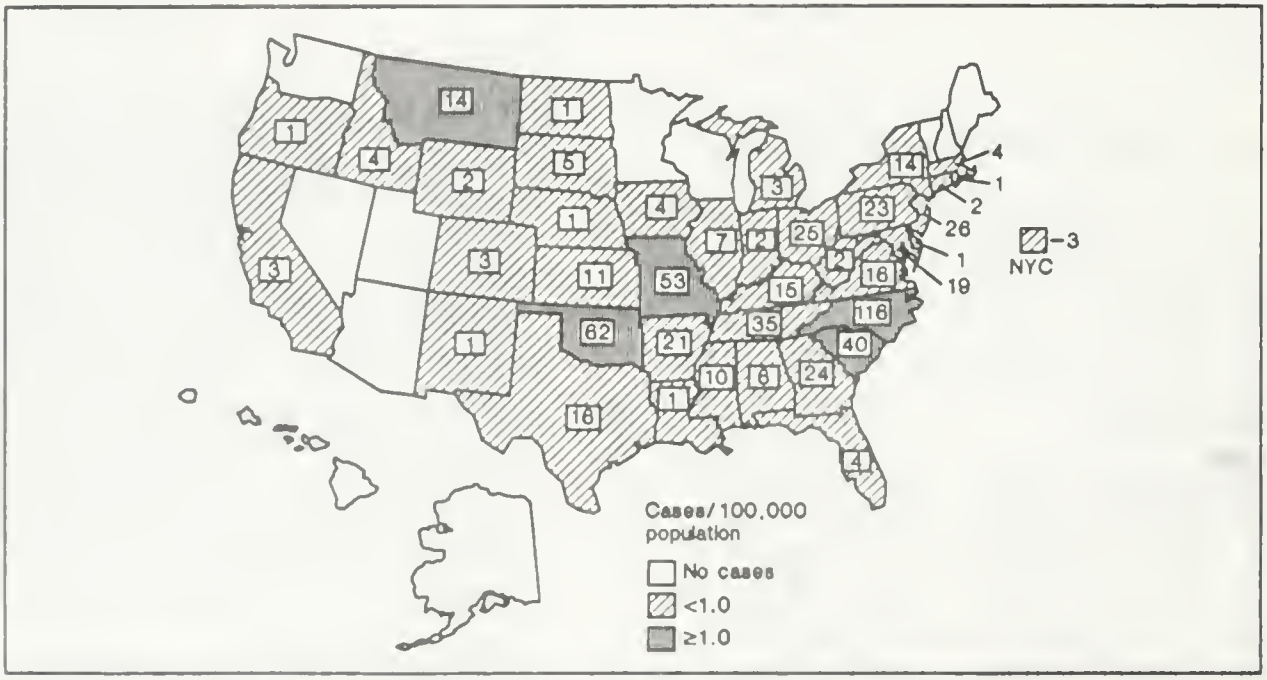
3. Exposure: Exposure is defined as having been in wooded, brushy, or grassy areas (potential tick habitats) in an endemic county no more than 30 days prior to the onset of EM. A history of tick bite is not required.

4. Endemic county: An endemic county is one in which at least 2 definite cases have been previously acquired or a county in which a tick vector has been shown to be infected with B. burgdorferi.

5. Laboratory confirmation: Laboratory confirmation of infection with B. burgdorferi is established when a laboratory isolates the spirochete from tissue or body fluid, detects diagnostic levels of IgM or IgG antibodies to the spirochete in serum or CSF or detects a significant change in antibody levels in paired acute and convalescent serum samples. States may determine the criteria for laboratory confirmation and diagnostic levels of antibody. Syphilis and other known causes of biologic false positive serologic test results, should be excluded as appropriate, when laboratory confirmation has been based on serologic testing alone.

NOTE: It should be emphasized that this is an epidemiologic case definition intended for surveillance purposes.

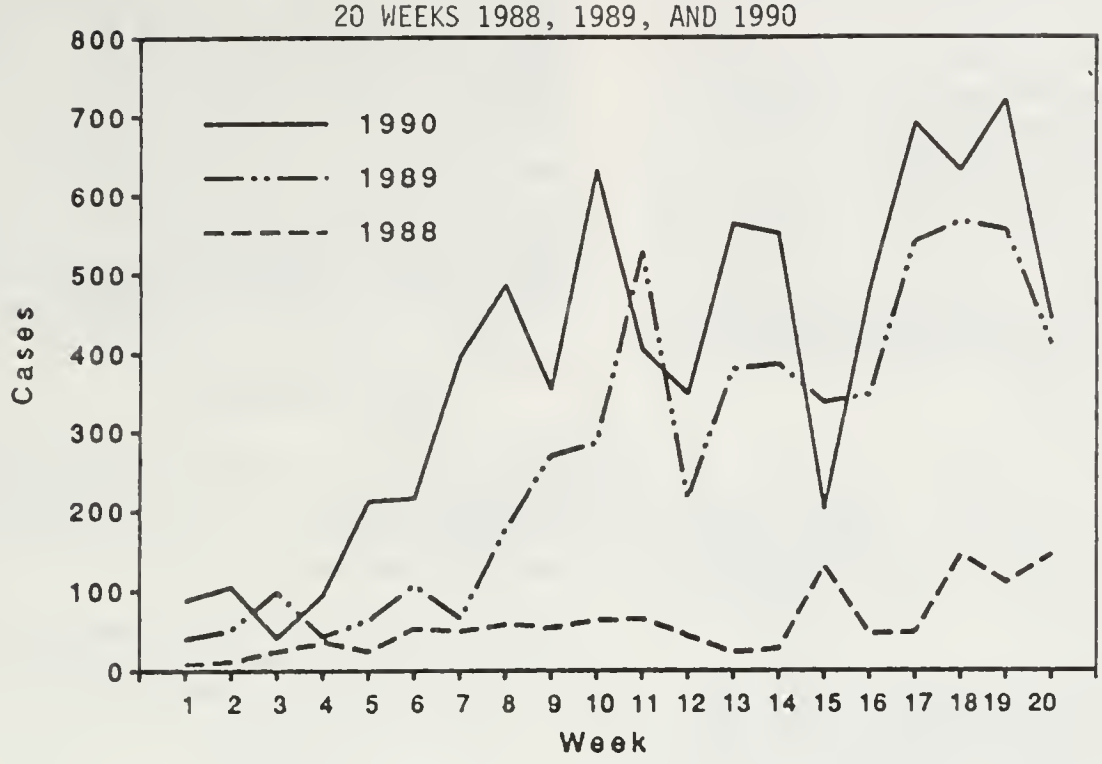
Reported cases and rates of Rocky Mountian spotted fever, by state - United States, 1989



Rocky Mountain Spotted Fever United States, 1989

In 1989, state health departments reported 603 cases of Rocky Mountain spotted fever (RMSF) to CDC, a 2.0% decrease from the 615 cases reported in 1988. The incidence rate was 0.25% per 100,000 persons. Of the 603 cases, 224 (37.1%) were reported from the South Atlantic region and 100 (16.6%) from the West South Central region. Oklahoma had the highest rate (62 cases, 1.0 per 100,000); other states with high rates were North Carolina (118 cases, 1.8 per 100,000), Montana (15 cases, 1.9 per 100,000), South Carolina (40 cases, 1.1 per 100,000) and Missouri (53 cases, 1.0 per 100,000).

REPORTED CASES OF MEASLES, BY WEEK - UNITED STATES, FIRST 20 WEEKS 1988, 1989, AND 1990



Measles in 1990 (First 20 Weeks)

For the first 20 weeks of 1990 (January 1 - May 19), a provisional total of 7,653 measles cases was reported, a 39.6% increase over the 5,484 cases reported for the same period in 1989. Cases have been reported from 48 states and the District of Columbia.

Detailed information has been provided on 5,180 (67.7%) of the 7,653 cases. Of these 5,180 patients, 2,187 (42.2%) were children less than 5 years of age, including 675 (13.0%) of total) less than 12 months of age.

Vaccination status was reported for 5,178 patients. Of these 1,483 (28.6%) were appropriately vaccinated and 3,695 (71.3%) were unvaccinated. Among the unvaccinated patients, routine vaccination was indicated for 1,839 (49.8% [35.5% of total]). Routine vaccination was not indicated for 1,252 (24.2%) patients. Although most of these were children less than 16 months of age (86.7%) 604 (11.7%) patients were unvaccinated for other reasons (e.g., religious or philosophic exemptions).

At least 88 measles outbreaks are known to be occurring in 25 states. These outbreaks involve preschool-ages children (seven outbreaks); school-aged children (five); college students; and other groups such as migrant farm workers and Amish populations. The largest outbreak is occurring in Dallas, where an estimated 2,900 confirmed and suspected cases have been reported since December 1, 1989. This outbreak involves primarily unvaccinated preschool-aged children,. Outbreaks among preschool-age children are also continuing in Chicago, Los Angeles and Milwaukee.

Since January 1, 35 suspected measles-associated deaths have been reported. Most deaths have occurred in unvaccinated preschool-aged children.

Reported by: Division of Immunization, Center for Prevention Services, CDC.

T.B. Elimination Plan Continued

In the April, 1990 edition of the Montana Morbidity Report a discussion was started concerning the elimination plan to eradicate the U.S. of tuberculosis. The ultimate control mechanism in tuberculosis elimination is to prevent infection, whether it be primary, secondary or tertiary prevention. In the April issue, five items related to improving case prevention were presented and in this issue five more will be presented. The items relating to preventing infection among persons exposed to an infectious case of tuberculosis or preventing tuberculosis among contacts are continued as follows:

6. Consideration should be given to routinely obtaining sputum for mycobacterial smear and culture from symptomatic nursing home residents thought to have a lower respiratory tract infection.

7. Tuberculosis patients and persons suspected of having tuberculosis should be interviewed within three days after the health department receives the case report by a person who has had specific training in contact interviewing.

8. Close contacts should be examined within seven days after the index case is diagnosed.

9. Infected contacts should be placed on preventive therapy if there is no evidence of clinical disease.

10. A child whose skin test shows no evidence of infection and who is a close contact of someone with infectious tuberculosis should be placed on preventive therapy until skin testing (three months after contact is broken) confirms the absence of infection.

11. All persons identified with HIV infection should be tuberculin tested. Those with positive tuberculin reactions or history of a positive tuberculin reaction (without active disease) should be considered for preventive therapy, regardless of age.

Preventive therapy is not prescribed as often as it should be. Completion of preventive therapy after it's prescribed is often not accomplished. Several years ago when MDHES was monitoring completion for Isoniazid preventive therapy, it was found approximately 22% of persons prescribed the medication actually took the course prescribed. This was at the time that one year of therapy was indicated and since the therapy time has been cut to six months, completion rates may be better. For elimination of tuberculosis, persons must be prevented from becoming cases. Preventive therapy is cost effective and safe when the patient is monitored frequently. There will be presentation of the last seven items concerning case prevention in the next issue of the Morbidity Report.

NEW PROGRAM CLERK

We would like to announce the placement of Jackie Bradshaw as the new Immunization Program Clerk. Jackie will be answering the phone, taking vaccine orders and doing our vaccine inventory work.

Jackie is new in the area, from Boise, ID and is looking forward to getting to know the vaccine providors personally.

* *
* HIV/AIDS INFORMATION *
* *

FDA Licenses First Test Kit for Antibody to Human Immunodeficiency Virus Type 2 (HIV-2)

On April 25, 1990, FDA licensed the first test kit that detects antibody to human immunodeficiency virus type 2, or HIV-2, a second, but far less common cause of AIDS than the human immunodeficiency virus type 1, or HIV-1.

Since the virus is rare in the United States, FDA will not require its use by blood banks at this time. However, the test may be used for epidemiologic studies, such as monitoring to determine if there is any spread of HIV-2 infection in the United States.

The first confirmed case of AIDS caused by HIV-2 infection in the United States was reported in 1987, and only 16 additional cases of HIV-2 infection have been reported in this country. Most known infections with HIV-2 have occurred in the general region of West Africa, although some

nations in that area have not yet reported any cases.

The health consequences of HIV-2 infection are similar to those of HIV-1. Both are transmitted among adults primarily by sexual contact with infected partners, intravenous drug use and contaminated blood or blood products.

The test uses the enzyme-linked immunosorbent assay, or ELISA, format. A "reactive" reading with the screening test means that an individual may have been exposed to HIV-2 and that the body is producing antibodies to the virus. Since HIV-1 and HIV-2 are so closely related, tests for the antibody to one virus often cross-react with the other.

Because of the possibility of false positives, FDA recommends that reactive results to the HIV-1 or HIV-2 antibody ELISA tests be validated with Western blot tests. The manufacturer will provide in-house Western blot testing services specific to HIV-2 for validation.

The test will be manufactured by Genetics Systems Corporation of Seattle, Washington.

MONTANA
RESIDENT AND NON-RESIDENT AIDS CASES*
Acquired Immunodeficiency Syndrome (AIDS)
Definitive and Presumptive AIDS Cases
Surveillance Report - 5/1/90 to 5/31/90

1. Disease Category

Disease Category	Adult/Adolescent Cases (%)	Deaths (%)
PCP	30 (48)	20 (67)
Other Disease w/o PCP	30 (48)	19 (63)
KS Alone	2 (3)	0 (0)
No Diseases Listed	0 (0)	0 (0)
Total	62 (100)	39 (63)

2. Age

Age	Cases (%)
Under 13	0 (0)
13-19	1 (2)
20-29	19 (31)
30-39	26 (42)
40-49	10 (16)
Over 49	6 (10)
Unknown	0 (0)
Total	62 (100)

3. Race/Ethnicity

Race/Ethnicity	Adult/Adolescent Cases (%)
White, Not Hispanic	57 (92)
Black, Not Hispanic	1 (2)
Hispanic	2 (3)
Native American	2 (3)
Unknown	0 (0)
Total	62 (100)

4. Exposure Category

Exposure Category	Adult/Adolescent Males (%)	Females (%)	Total (%)
Homosexual or Bisexual Men	37 (60)	0 (0)	37 (60)
Intravenous (IV) Drug User	6 (10)	0 (0)	6 (10)
Homo/Bi IV Drug User	7 (11)	0 (0)	7 (11)
Hemophiliac	3 (5)	0 (0)	3 (5)
Heterosexual Contact	0 (0)	4 (6)	4 (6)
Transfusion With Blood/ Products	0 (0)	1 (2)	1 (2)
None of the Above/Other	3 (5)	1 (2)	4 (6)
Total	56 (90)	6 (10)	62 (100)

Source: Montana AIDS/STD Program, MDHES, through May 31, 1990.

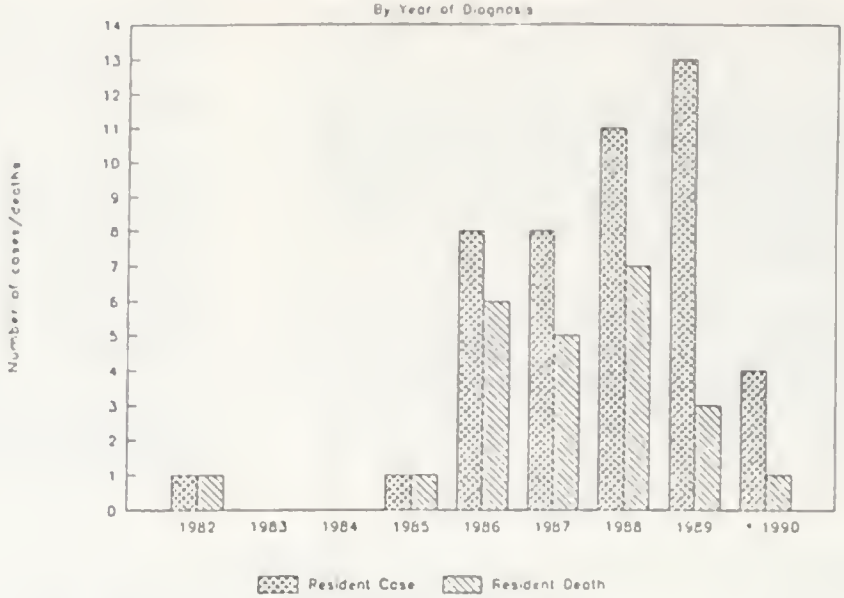
*Includes 46 Montana AIDS cases and 16 cases reported to Centers for Disease Control from other states who are living in Montana.

As of May 31, 1990 there have been 257 positive HIV tests from 20,685 tests conducted through the MDHES Public Health Laboratory.

Nationally, as of April 30, 1990, 132,510 cases of AIDS and 80,798 deaths have been reported to the Centers for Disease Control.

Montana Resident AIDS Case and Death

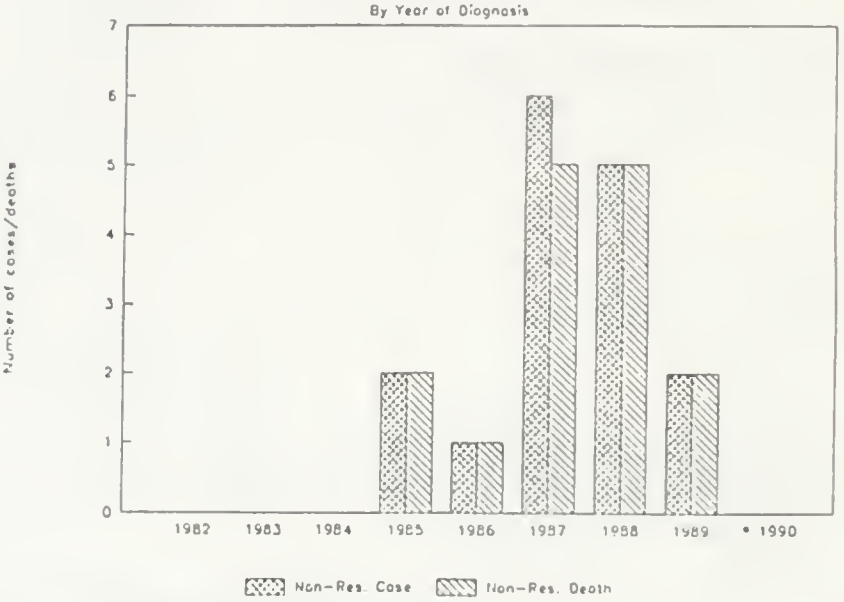
By Year of Diagnosis



Resident = case diagnosed while a resident of Montana.

MT Non-Resident AIDS Case and Death

By Year of Diagnosis



Non-resident = case diagnosed while residing in another state, but now a resident of Montana.

Source: Montana Department of Health and Environmental Sciences, AIDS/STD Program, June 5, 1990.

* 1990 numbers are through May 31, 1990.

Notice to Montana Morbidity Report Subscribers

We are in the process of updating our mailing list. If you are receiving duplicate copies or have a name or address change, please inform us. Also, if you know of anyone wishing to receive a copy of this publication or if you wish to discontinue receiving this publication, please contact us at: Montana Department of Health and Environmental Sciences, Montana Morbidity Report, Communicable Disease Section, Cogswell Building, Room C-303, Helena, Montana 59620.

Hepatitis Hotline

CDC's Hepatitis Branch, Division of Viral and Rickettsial Diseases, Center for Infectious Diseases, now has an automated telephone system that provides information on viral hepatitis, including modes of transmission, prevention, serologic diagnosis, infection control and statistics. Persons requesting information on viral hepatitis should call the CDC Disease Information Hotline at (404) 332-4555.

MAY 1990	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead															
Big Horn			1			1					1		1		
Blaine															
Broadwater															
Carbon															
Carter															
Cascade	1		2	2							1	1			
Chouteau															
Custer															
Daniels															
Dawson													1		
Deer Lodge															
Fallon															
Fergus											1	2			
Flathead	1					1					1				
Gallatin	2		3	2			1						4		
Garfield															
Glacier				1	1	1									
Golden Valley															
Granite															
Hill				1			1								
Jefferson															
Judith Basin															
Lake						2									
Lewis & Clark			1	2											
Liberty															
Lincoln						1					2				
McCone															
Madison															
Meagher															
Mineral															
Missoula	2			1			1						3		
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[illegible]stone	1		1	5		2				1			5		
19 90	8		11	16	1	9	3	0	0	1	8	7	15	0	0
19 89	8	115	9	13	1	2	3	0	1	0	4	8	2	5	3
19 88	4	184	13	35	0	4	4	2	0	0	2	23	8	20	0
19 90	24		38	50	2	29	18	1	2	2	12	19	25	12	7
19 89	11	504	32	81	2	15	16	1	0	1	22	26	21	58	5
19 88	11	702	48	158	4	17	20	4	3	0	25	90	20	20	0

R DISEASES: Bacterial Meningitis Unspecified: Carbon - 1, Cascade - 1, Flathead - 1

[illegible]kenpox: Cascade - 13, Colorado Tick Fever: Beaverhead - 1, Bighorn - 1, Ravalli - 1

[illegible]verbow - 1, Legionellosis: Rosebud - 1, Pertussis: Ravalli - 5, Late Latent Syphilis: Hill - 1.

PLEASE DISREGARD ALL "TO-DATE" TOTALS. CORRECTED TOTALS WILL COME OUT IN THE JUNE MORBIDITY REPORT.

Epidemiology Manual from Louisiana

The Louisiana Department of Health and Hospitals, Office of Public Health, has produced an epidemiology manual for public health nurses in their state. At the recent Council of State and Territorial Epidemiologists' meeting copies were made available for other states to review and obtain. A copy is available at MDHES from the Communicable Disease Section. The table of contents includes a section on Communicable Disease Nursing, Disease Outbreak Investigation, Elements of Health Unit Epidemiology, Data System, Reportable Diseases Requiring Followup. In the Reportable Disease Requiring Followup section there is discussion of 17 diseases. There is a section on Reportable Diseases Requiring Additional Information. Some of them may be diseases also discussed in the Reportable Diseases Requiring Followup section. Another section discusses Less Common Reportable Diseases. The two final sections are entitled Non-reportable Diseases -- Diseases Under Special Surveillance and Laboratory Specimen Collection. There are also appendices with information such as interpreting laboratory reports relative to the sero-diagnosis of viral hepatitis. A glossary is included.

Public health nursing agencies wishing to see a model for a public health nurse epidemiology manual may be interested in taking a look at this one from Louisiana. It's 226 pages in length and therefore, cannot be copied by the Communicable Disease Section. However, if you would like to take a look at it to see if sections of it might be a basis for your own manual, you can look at the copy at the Communicable Disease Section at MDHES or we could mail it to you and ask you to return it a week later. The manual is geared to practical application in Louisiana, therefore, you would have to adapt it to conform with the differences between Montana Communicable Disease Statute and Rules as well as practical applications such as phone numbers and contact persons. If you wish to see this manual, you can put in your request by contacting the Communicable Disease Section at 444-4740 or writing to the Communicable Disease Section, Cogswell Building, Helena, Montana 59620.

Volume: 14 - 5 Month of: MAY 19,1990

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JUNE 19, 1990

Montana State Department of Health and Environmental Sciences

* *
* HIV/AIDS INFORMATION *
* *

Update on HIV Seroprevalence Surveys: Childbearing Women

The December 1989 Montana Morbidity Report carried a story concerning the Human Immunodeficiency Virus (HIV) seroprevalence survey being conducted in Montana. The survey is one of 43 throughout the United States initiated under the guidance of the Centers for Disease Control since 1988. The purpose of this survey is to obtain relatively unbiased estimates of the levels and trends of HIV infection in the population of women delivering live children in the United States. Secondary objectives include studying passive transfer of maternal antibodies for HIV to neonates. Information from the surveys are to fulfill local public health planning and evaluation needs, meet the national surveillance responsibilities of the Centers for Disease Control and meet the HIV epidemiologic research needs of the National Institutes of Health.

A 61-page guidance document, HIV Seroprevalence Survey in Childbearing Women: Testing Neonatal Dry Blood Specimens on Filter Paper for HIV Antibody, from Centers for Disease Control has been used to direct the surveys. Montana has had visits from Centers for Disease Control staff prior to and since implementation of the survey. The Centers for Disease Control awarded money in the present AIDS grant for continuation of the survey through December. As of June, 1990, over 16,000 tests have been done. In the last quarter (April-June, 1990), three tests were reported as repeatedly positive. This survey is done by testing the same specimens submitted for newborn metabolic screening. No identification of those tested can be made.

The implications of a blind study were discussed prior to the implementation of these sero-surveys throughout the United States. It needs to be re-emphasized that these serological surveys should not be used in lieu of prenatal/neonatal screening and testing and counseling programs in other settings. All women of childbearing age with identifiable risk for HIV infection should be routinely counseled and tested for HIV infection independent of and concurrent with the conduct of these surveys. Counseling and testing should be provided to women during family planning visits or as part of pre-natal health care programs or at the time of delivery.

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EDUCATION AND CONFERENCES

America Responds to AIDS - PSAs

The Centers for Disease Control (CDC) will be releasing Phase V of the America Responds to AIDS public service campaign. The primary goal of this campaign is to encourage Americans to take steps to prevent HIV infection and AIDS. To do this, individuals must first understand the relationship between HIV and AIDS, the importance of addressing risk behaviors and the benefits of seeking early medical intervention if infected.

National AIDS Names Quilt Project

A national convention of 1,500 youth from the Episcopal Church will be meeting at the University of Montana August 14-18, 1990. The youth group is planning to sponsor the cost of bringing the AIDS "names" quilt to the convention. A host committee of people (outside the convention group) met in Missoula on June 25, to discuss how word about the quilt project could be dispersed in the area and throughout the state. Donations may be raised by the host committee through the quilt project to be used locally (distributed amongst 501-3-C non-profit community-based organizations providing services to persons with HIV/AIDS in Montana).

The quilt project is an opportunity to provide a focus on the AIDS issue in the area.

Physician/Nurse Survey

A comprehensive national study of physicians' and nurses' attitudes, knowledge and practices in relation to AIDs is being conducted by the Columbia University School of Public Health in collaboration with NORC at the University of Chicago. The study is being funded by the U.S. Public Health Service. A nationwide sample of 2,700 physicians and nurses will be asked to participate in the study between mid-July and December.

Physicians' and nurses' knowledge about AIDS and their willingness to counsel well patients about the risk of contracting AIDS and to provide care for persons with AIDS are critical issues that affect the success of AIDS prevention programs and the care and treatment of persons with AIDS.

RESOURCES

Publication Announcement

The Guide to Resources on Women and AIDS, developed by the Center for Women Policy Studies, is now available. The guide offers a critical overview of issues for women in the AIDS crisis. To order a copy send a check or money order for $20.00 to: Publications, Center for Women Policy Studies, 2000 P Street, N.W., Suite 508, Washington, DC 20026.

AIDS Resource Directory Updates

Please make the following changes to your AIDS Resource Directory:

Page 5:
AMERICAN CIVIL LIBERTIES UNION -MONTANA
Tel: 248-1086

Page 29:
BUTTE AIDS SUPPORT SERVICES (BASS)
P. O. Box 382
Butte, MT 59703
Tel: 496-6125

BUTTE-SILVER BOW AIDS TASK FORCE
Tel: 723-6507

Page 32:
JEFFERSON COUNTY
Karan Kunz
P. O. Box #1
Boulder, MT 59632
Tel: 225-4231

Written requests/private appointments.

Page 33:
TRI-COUNTY FAMILY PLANNING CLINIC
201 South Main, Room 218
Helena, MT 59601
Tel: 442-3830

Page 49
DEERING COMMUNITY HEALTH CENTER - CONTACT:
David Herrera

Page 52
YELLOWSTONE AIDS PROJECT
P. O. Box 1748
Billings, MT 59103
Tel: 252-1212 (Hotline - 24 hours)
245-2029 (Office)

(Billings AIDS Support Network (BASN) and Billings AIDS Task Force have merged into what is now called Yellowstone AIDS Project.)

AIDS Quilt visits Missoula in August

A portion of the Names Project quilt will be on display at the University of Montana Fieldhouse beginning with the unfolding of the Quilt which will start at 8:30 pm on Thursday, August 9th. The Quilt will be on display there from 12:00 noon to 9:00 pm Friday and Saturday, August 10th and 11th. There may be a brief showing on the 12th, but that is still tentative.

"NOTICE"

International Health Requirements and Recommendations Information Hotline

The Centers for Disease Control has instituted a pilot program for health information for foreign travel. Requirements and recommendations for international travel are now available 24-hours-a-day, with the use of a touch-tone phone, by calling:

404-332-4559

Callers can select any one or all of the informational messages by following the instructions which are given. Be sure to have a pen and paper available to write down the names of drugs and vaccines. The information will be updated as needed.

TREATMENT AND RESEARCH

FDA Glove Regulations

The Food and Drug Administration is enforcing tougher standards for medical gloves. The new regulations will be published in the Federal Register in May or June. Thirty days from that date, the regulations will be effective.

The action by the FDA is a continuing effort by the agency to scrutinize glove quality in light of the AIDS epidemic. In addition, the Health Industry Manufacturers Association plans to propose a joint educational effort with the FDA to teach health care workers proper use and storage of gloves.

Ref: Federal Register 1989; 54[223]: 48, 218-48, 222.

Disk Diffusion Antimicrobial Susceptibility Test of Neisseria gonorrhoeae

The following is an excerpt from the MMWR, March 16, 1990, Vol. 39, No. 10 explaining a well-standardized laboratory method to monitor the susceptibilities of gonococcal isolates recommended by NCCLS. For the complete article, please refer to the MMWR or write to: Montana AIDS/STD Program, Cogswell Building, Room C-314, Helena, MT 59620.

Antimicrobial resistance to Neisseria gonorrhoeae has developed to each of the agents that have been recommended for gonorrhea therapy. As a result, a well-standardized laboratory method to monitor the susceptibilities of gonococcal isolates has been recommended by the National Committee for Clinical Laboratory Standards (NCCLS). The NCCLS recently completed a multi-center study to standardize disk diffusion (and agar dilution) susceptibility tests for N. gonorrhoeae and to establish interpretive criteria and quality control guidelines. The recommended test medium is GC base agar with a defined "XV-like" supplement. Control organisms are N. gonorrhoeae ATCC 49226 (CDC F-18), N. gonorrhoeae WHO V, and Staphylococcus aureus ATCC 25923.

Interpretive criteria based on expected treatment failure rates for single-agent therapy with penicillin, tetracycline, spectinomycin, or ceftriaxone have been selected. Resistance to penicillin is defined as a zone diameter of $\leq$ 26 mm *10-U disk), corresponding to a minimum inhibitory concentration (MIC) of $\geq$ 2 ug/mL. Strains producing β-lactamase (penicillinase-producing N. gonorrhoeae [PPNG] produce zones sizes of $\leq$19 mm. Resistance to tetracycline is defined as a zone diameter of $\leq$30 mm (30-ug disk), also corresponding to an MIC of $\geq$2 ug/mL. Strains producing zone diameters of $\leq$19 mm may be presumptively identified as having high-level plasmid-mediated resistance to tetracycline (tetracycline-resistant N. gonorrhoeae [TRNG]); the corresponding MIC of these strains is $\geq$ 16 ug tetra-

MONTANA DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES

MONTANA
RESIDENT AND NON-RESIDENT AIDS CASES*
Acquired Immunodeficiency Syndrome (AIDS)
Definitive and Presumptive AIDS Cases
Surveillance Report - 6/1/90 to 6/30/90

1. Disease Category

	Adult/Adolescent Cases (%)	Deaths (%)
PCP	30 (48)	20 (67)
Other Disease w/o PCP	31 (49)	20 (66)
KS Alone	2 (3)	0 (0)
No Diseases Listed	0 (0)	0 (0)
Total	63 (100)	40 (63)

2. Age

	Cases (%)
Under 13	0 (0)
13-19	1 (2)
20-29	19 (30)
30-39	27 (43)
40-49	10 (16)
Over 49	6 (10)
Unknown	0 (0)
Total	63 (100)

3. Race/Ethnicity

	Adult/Adolescent Cases (%)
White, Not Hispanic	58 (92)
Black, Not Hispanic	1 (2)
Hispanic	2 (3)
Native American	2 (3)
Unknown	0 (0)
Total	63 (100)

4. Exposure Category

	Adult/Adolescent Males (%)	Females (%)	Total (%)
Homosexual or Bisexual Men	38 (60)	0 (0)	38 (60)
Intravenous (IV) Drug User	6 (10)	0 (0)	6 (10)
Homo/Bi IV Drug User	7 (11)	0 (0)	7 (11)
Hemophiliac	3 (5)	0 (0)	3 (5)
Heterosexual Contact	0 (0)	4 (6)	4 (6)
Transfusion With Blood/ Products	0 (0)	1 (2)	1 (2)
None of the Above/Other	3 (5)	1 (2)	4 (6)
Total	57 (90)	6 (10)	63 (100)

Source: Montana AIDS/STD Program, MDHES, through June 30, 1990.

*Includes 47 Montana AIDS cases and 16 cases reported to Centers for Disease Control from other states who are living in Montana.

As of June 30, 1990 there have been 258 positive HIV tests from 21,181 tests conducted through the MDHES Public Health Laboratory.

Nationally, as of May 31, 1990, 136,204 cases of AIDS and 83,145 deaths have been reported to the Centers for Disease Control.

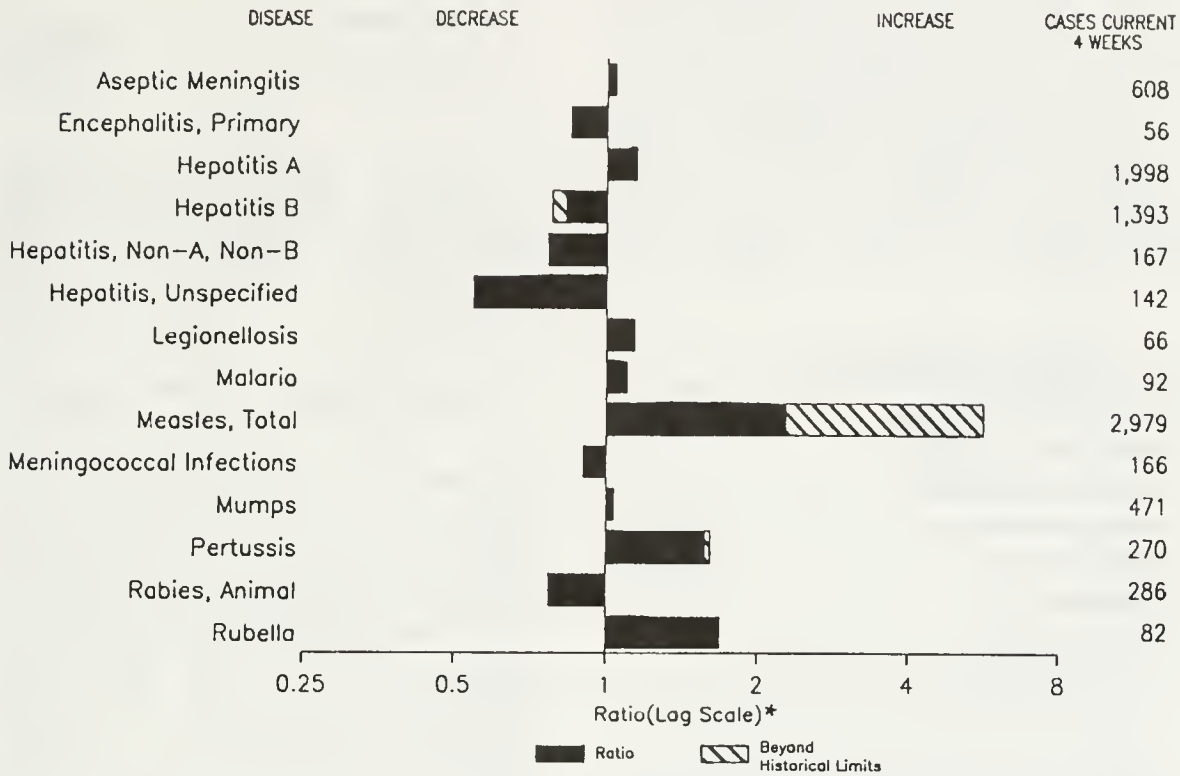
cycline/mL. Spectinomycin-resistant isolates produce zone sizes of ≤ 14 mm (MIC ≥ 128 ug spectinomycin/mL) with a 100-ug disk. Only a susceptible criterion for ceftriaxone has been established (30-ug disk) because of the absence of treatment failure in patients treated with ceftriaxone, 250 mg, IM.

Cure rates of ≤ 85% would be expected for patients infected with organisms resistant to an antimicrobial agent when treated with that agent alone. Cure rates of ≥ 95% would be expected for patients infected with susceptible organisms. Cure rates lower than those for infections caused by susceptible organisms may be expected for patients infected with moderately susceptible organisms.

Rabies and Rickettsial Diseases Hotline

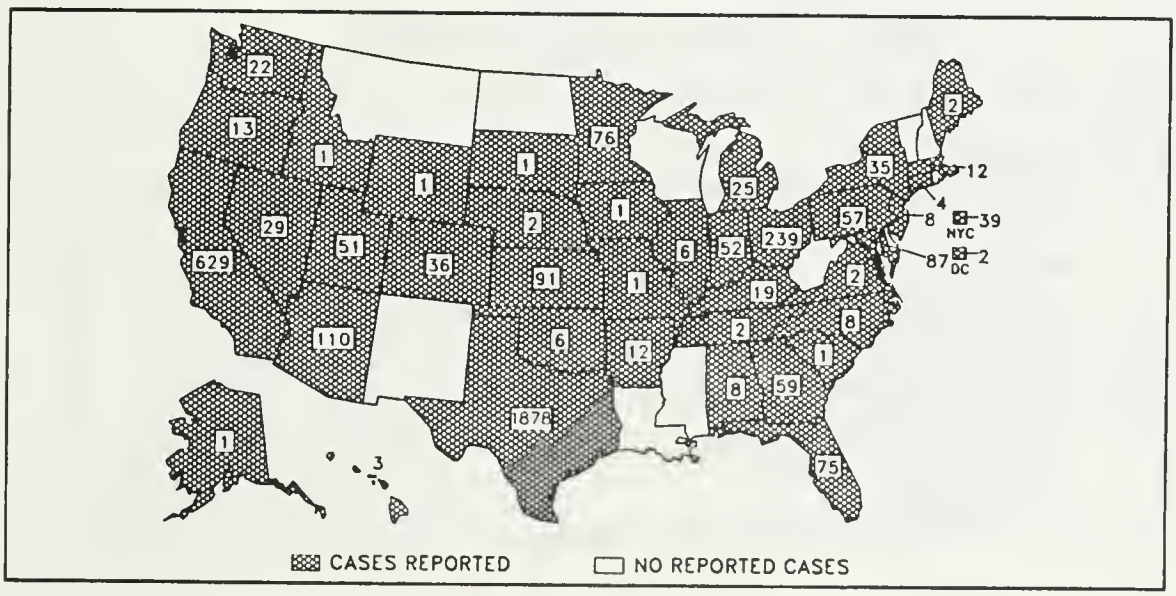
CDC's Viral and Rickettsial Zoonoses Branch, Division of Viral and Rickettsial Diseases, Center for Infectious Diseases, now has a 24-hour-a-day automated telephone system that provides information to the public on rabies, Rocky Mountain spotted fever and human ehrlichiosis. Menu options include information on animal and tick bites, requests for written information, rabies prevention recommendations for international travelers and the procedure for reporting rabies vaccine reactions. To access this information, call the CDC Information Hotline at (404) 332-4555.

Notifiable disease reports, comparison of 4-week totals ending June 30, 1990, with historical data — United States



*Ratio of current 4-week total to mean of 15 4-week totals (from comparable, previous, and subsequent 4-week periods for past 5 years).

Reported cases of measles, by state — United States, weeks 23–26, 1990



Montana Tick Species

National and state surveillance for Lyme Disease (LD) has been intensified in recent years as information about the disease and the causative agent (Borrelia burgdorferi) has been accumulating. The incidence in most areas of the U.S. is rising each year, probably due to improved awareness and recognition of LD, as well as actual increasing incidence and geographic spread. However, among the ticks indigenous to Montana, or even found here, none are known to be competent vectors of LD. Tick species known to be indigenous to Montana are shown in Table 1 and include two species of Ixodes.

TABLE 1 MONTANA TICK SPECIES

- Dermacentor andersoni
- Dermacentor variabilis
- Dermacentor albipictus
- Riphicephalus sanguineus
- Ixodes sculptus
- Ixodes kingi
- Otobius megnini

Table 2 shows the clearly identified vectors for LD; none of these occur in Table 1.

The known LD vectors are Ixodes dammini, I. scapularis and I. pacificus. I. dammini (the deer tick) is, to a large extent, responsible for transmission of B. burgdorferi from animal to man.

TABLE 2 LYME TICK VECTORS

SPECIES	INFECTION RATE (COMMENT)
Ixodes dammini	up to 40%
Ixodes scapularis	up to 4%
Ixodes pacificus	up to 0.4%
Ixodes angustus	status (?)

The known tick vectors for Borrelia hermsii (relapsing fever) include Ornithodoros turicata and O. hermsii. Apparently the known vectors for either form of borreliosis have not yet been detected in Montana.

The Ixodes species known to be indigenous to this region are shown in Table 3.

The presence of additional tick species in Montana is the subject of continuing identification efforts by entomologist, Ken Quickenden, Ph.D, R.S. of MDHES' Food and Consumer Safety Bureau (444-2408). We hope for additional knowledge about both populations and distribution of known species, as well as the discovery of previously unknown vector species.

The submittal of specimens is encouraged, preferably live, in tight containers containing a blade of grass for humidity control, to:

Kenneth Quickenden, Ph.D
Food/Consumer Safety Bureau
Cogswell Building, Room A104
Helena, MT 59620

TABLE 3 REGIONAL IXODES DISTRIBUTION

SPECIES	MT	ID	ND	SD	WY
Ixodes sculptus	X			X	X
Ixodes kingi	X			X	X
Ixodes eastoni				X	
Ixodes spinipalpis				X	
Ixodes muris				X	
Ixodes cookei				X	X

JUNE 1990	Campylobacter, diarrhea	Chlamydia, sexually transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead		2													
Big Horn		2													
Blaine															
Broadwater															
Carbon															
Carter															
Cascade	4	16	6	3			1					1	3		
Chouteau		1													
Custer		5		2											
Daniels															
Dawson							1								
Deer Lodge				1	1										
Fallon															
Fergus			1												
Flathead	2	5	1												
Gallatin	1	14	1	1									1		
Garfield															
Glacier		3	1			7	1		1						
Golden Valley															
Granite															
Hill		1													
Jefferson															
Judith Basin															
Lake		3		1		3									
Lewis & Clark	1	8											1		
Liberty															
Lincoln		3				1									
McCone															
Madison	1	1													
Meagher															
Mineral															
Missoula	6	9		1		1	1		1				3		
Musselshell															
Park		1	1											1	
Petroleum															
Phillips															
Pondera															
Powder River															
Powell	1														
Prairie															
Ravalli		1										1			
Richland													1		
Roosevelt		3	1	1											
Rosebud		2				1									
Sanders															
Sheridan															
Silver Bow	2	7													
Stillwater		2													
Sweet Grass															
Teton		1										1			
Toole											1	1			
Treasure															
Valley		1													
Wheatland															
Wibaux															
Yellowstone	4	26	2	10	1	1	1			1	1				
MONTHLY TOTAL 19 90	22	117	14	20	1	14	5	0	1	2	2	4	9	1	0
MONTHLY TOTAL 19 89	10	74	12	12	1	10	6	1	0	0	9	11	6	3	0
MONTHLY TOTAL 19 88	8	164	20	28	2	0	7	1	0	0	5	15	4	4	5
TOTAL TO DATE 19 90	46	762	71	99	6	61	38	2	4	8	34	26	51	22	10
TOTAL TO DATE 19 89	29	693	53	106	4	27	25	2	1	1	35	45	29	66	8
TOTAL TO DATE 19 88	23	1050	81	221	6	21	31	7	3	0	33	128	32	44	5

OTHER DISEASES: ASEPTIC MENINGITIS: Missoula - 1, BACTERIAL MENINGITIS UNSPECIFIED: Gallatin - 1, CHICKEPOX: Cascade - 16, Flathead - 1, Roosevelt - 1, Silverbow - 1, Yellowstone - 5, COLORADO TICK FV.: Missoula - 2, Powell - 1, CYTOMEGVIR ILL: Gallatin -1, PERTUSSIS: Missoula - 1, Ravalli - 17, ROCKY MTN. SPOTTED FV.: Ravalli - 2, Yellowstone - 1, YERSINA ENT: Silverbow - 1

T.B. Elimination Plan (Continued)

In the April and May, 1990 editions of the Montana Morbidity Report a discussion has been presented concerning the elimination plan to eradicate the U.S. of tuberculosis. The following is presentation of the last group of items related to this topic.

12. All other recognized high risk, infected persons should be considered for preventive therapy regardless of age. This includes recently infected persons (i.e., persons who had negative skin test results who have converted to positive test results, persons with chest radiographic findings consistent with past tuberculosis, and those with medical risk factors known to substantially increase the risk of tuberculosis, e.g., silicosis, below ideal body weight, gastrectomy, immunosuppressive therapy).

13. Screening of refugees, immigrants, and entrants from high incidence countries should be continued and infectious persons with tuberculosis excluded until they become non-infectious. These groups should also be screened for tuberculosis infection (without disease) unless contraindicated, those with infection (without disease) should be started on preventive therapy either before, or within two months after, their entry into the United States.

14. Infected persons placed on preventive therapy should complete a full course of treatment.

15. Twice weekly, directly observed preventive therapy should be used whenever necessary to insure compliance, especially if the number of persons on daily supervised preventive therapy should overextend the personnel resources assigned to the program.

16. Patients on INH preventive therapy must be carefully monitored on a monthly basis for compliance and signs and symptoms of toxicity. Spot testing of urine for INH metabolites is highly recommended when therapy cannot be observed directly. If signs or symptoms of toxicity appear, therapy should be stopped immediately and the patient re-evaluated. No more than one month's supply of medicine should be dispensed at any visit.

17. BCG vaccine should be considered in those rare situations in which other control measures cannot be applied and uninfected children are exposed to infectious persons who remain untreated.

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Vol. 14-7 JULY 1990

Montana State Department of Health and Environmental Sciences

REGIONAL MEASLES UPDATE

Washington

This state continues to experience additional measles cases as of this printing, in an outbreak that, by July 1 (26 weeks) had reached 266 cases, more than in any other full year since 1979. Most cases occurred in individuals who were unvaccinated (77.5) while 22.5% were vaccinated (live measles vaccine on or after first birthday).

Washington State Health Department officials relate that even though additional cases are still occurring, the outbreak is subsiding. By the end of August, over 280 cases are expected to have been reported with the actual measles morbidity somewhat higher.

A report in MMWR indicates that two persons aged 30 and 36 years, respectively, died from measles-related pneumonia (case-fatality rate: 9.2 deaths per 1000 cases), representing the first measles-related deaths in Washington since 1978. Fifty-nine (27%) patients were hospitalized for a total of 236 days.

To control this epidemic, the Washington State Department of Health provided more than 76,000 doses of measles vaccine, at a cost of $1.1 million, for use in vaccination clinics. These clinics were publicized in Spanish and English on radio and television, in newspapers, and by sound trucks driven through areas having a high proportion of Hispanic residents. In one severely affected county, the recommended age for measles vaccination was lowered to 12 months. In addition, susceptible students and staff were excluded from attendance at all 15 school where at least one case occurred; at 13 of these schools, there was no evidence of secondary transmission. At one of the two schools where secondary transmission occurred, all students were vaccinated.

Fifteen (7%) cases were in persons infected in Mexico and were linked to 41 (19%) additional cases. Sixteen cases were in persons from other states and were linked to two additional cases. Importation and nosocomial spread were both important in this outbreak.

At least 37 (17%) persons acquired measles through exposure in medical settings (three in physicians' offices, four on hospital wards and 30 in emergency rooms). These persons included 16 medical workers, who infected at least six other persons (including three hospital patients). Serosurveys conducted at two hospitals as part of vaccination programs indicated that

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199 (7%) of 1698 employees lacked immunity as defined by enzyme-linked immunosorbent assay. None of the 19 hospitals where patients were treated had an employment policy requiring measles immunity.

Many patients with measles were not isolated promptly because of initial misdiagnosis. At least nine measles patients at three hospitals presented with fever, cough, conjunctivitis and rash but were initially diagnosed as having hepatitis, viral syndrome, drug reaction or Kawasaki disease. They remained in emergency rooms for up to 13 hours, were hospitalized without isolation, or were sent home where additional exposures occurred in family members. At least 31 cases in family members, other hospital patients, visitors, or staff were linked to these nine patients.

According to the MMWR, in the Washington outbreak the lack of hospital employment policies requiring immunity to measles accounted for disease in medical workers, major disruptions in staffing, substanital expenses for serologic testing and vaccination during the outbreak and transmission from medical workers to others. Many states in this region are without written or mandatory immunity policies for most hospital and medical facilities, Montana included.

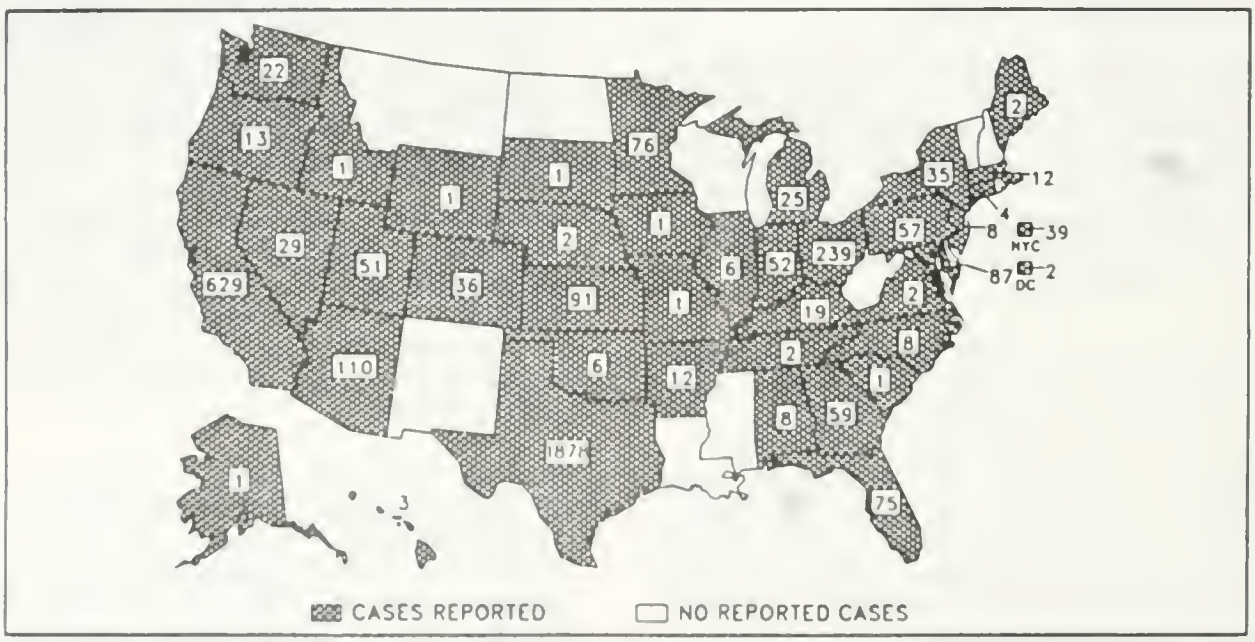
In December 1989, the Immunization Practices Advisory Committee (ACIP) recommendations were published that advised medical facilities to require all staff who will have direct patient contact to provide evidence of two live measles vaccinations, documentation of physician-diagnosed measles disease or laboratory evidence of immunity.

Montana

Montana reports show a total of six measles cases for 1990 (first 26 weeks) all "imported" from other states. All six were Montana residents who were exposed in another state to known cases and developed prodromal symptoms within a few days of return to Montana. Four were Flathead County residents, one Missoula and one Lewis and Clark County.

To date, there have been no spread cases identified. In the Lewis and Clark County

Reported cases of measles, by state — United States, weeks 23–26, 1990



case, a two dose measles requirement was used for all employees in the hospital where the case presented at the ER and was subsequently hospitalized.

Five of the six cases were unvaccinated and were four school age children. All four of these cases occurred after the school term ended.

During 1989 and 90, Montana Immunization Program personnel have been working with 7 selected hospitals in several communities, promoting the adoption of employee immunization policy and programs for employees in these hospitals.

To date, the Program Manager and Field Health Officers have visited 6 of the 7 hospitals.

As of January, 1989, an estimated 1296 (32%) of total employees in these 7 hospitals had not had the first dose of measles vaccine or lacked adequate documentation of immunity. Immunizations are ongoing at several of these hospitals. Four of those hospitals have reported to have immunized all persons who lacked measles and rubella documentation. One hospital reported only vaccinating persons who "wanted" to be immunized. No formal reports, regarding number of employees and number of employees with immunization documentation, have been requested from the hospitals to date. From available information, it is estimated that 64% of those employees who previously lacked the first dose of measles and rubella vaccine have now been immunized.

It is also estimated that 88% of the total number of employees in the target hospitals have now (June, 1990) received one dose against measles and rubella. The program will continue to work with the hospitals to improve in this area and promote the use of 2 doses of MMR.

Two Montana hospitals are reported to require measles immunity documentation while only one Montana hospital is reported to have a mandatory immunization policy which includes 2 doses of measles vaccine.

The Montana Department of Health and the U.S. Public Health Service recommend that all health care facilities have mandatory immunization policies which, at a minimum, require evidence of measles immunity as a condition for employment. The policy should cover all professional and non-professional staff, including physicians and volunteers.

STUDENT IMMUNIZATION LEVEL REPORTED UP 1% FOR 1989-90 SCHOOL YEAR

In the Immunization Program report to CDC for the first quarter of 1990 concerning immunization levels of K-12 students in Montana public schools, an increase to 98% was documented. The results are generated from a sample school population drawn from schools across the state totaling over 1,500 students.

TABLE I. Immunization Levels by Vaccine Type in K-12 School Attenders 1988 and 1989, Montana

Vaccine Category	Percent Immunized 1988-1989 School Year Results	1989-1990 School Year Results
Polio (3+ doses)	98%	99%
DTP/Td (3+ doses)	98%	99%
Measles Vaccine	98%	99%
Rubella Vaccine	98%	99%
Mumps Vaccine*	97%	99%
Combinations P(3+), D(3+), M, R	98%	98%

*Mumps reporting was not required at the time of the survey. Percent given is for schools who voluntarily reported.

Ninety-nine percent of K-12 attenders were immunized for each of the vaccine categories during the 1989-90 school year. Ninety-eight percent of the students were fully immunized. The increase in immunization levels this year is directly related to the new law change (effective July 1, 1989) which removed the personal exemption.

Table I numbers represent the children in school who are immunized in accord with the minimum requirements prescribed for school entry by state law and administrative rule. The small percentage not immunized in each category is made up of those not vaccinated due to religious exemption, medical exemption or on conditional status (waiting for the interval to receive a required dose). Montana school entry requirements are summarized in Table II.

In order to avoid confusion, it is noted

that these minimum requirements differ greatly from the recommended childhood immunization schedule. There have been significant changes in the HiB (15 months) and MMR vaccine categories (2 doses). Table III summarizes the most current recommendations. For complete detail refer to the ACIP recommendation document for each disease category and the General Recommendations on Immunization as published in MMWR. The most recent measles prevention (ACIP) document is found MMWR, December 19, 1989/V. 38,No. S-9.

TABLE II.

Requirements for Unconditional Attendance

Antigens	School Enterer	Attendee Age 7 or Above	Attendee beginning School Prior to 8/1/90
DTP, Td, DT	4 doses, one after 4th birthday	3 doses, one after 4th birthday	3 doses
OPV	3 doses, one after 4th birthday	3 doses, one after 4th birthday	3 doses
Mumps	1 dose after 1st birthday	--	--
Rubella	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday
Measles	1 dose after 1st birthday	1 dose after 1st birthday and after 1967	1 dose after 1st birthday and after 1967

TABLE III.

Recommendations for Active Immunization of Normal Adults and Children

Recommended Age Interval	Vaccine(s)	Comments
2 months ±	DTP-1, OPV-1	Can be given earlier in areas of high endemicity.
4 months ±	DTP-2, OPV-2	6 weeks to 2 month interval desired between OPV doses to avoid interference.
6 months ±	DTP-3	Additional dose OPV optional for high risk areas.
15 months*	DTP-4, OPV-3 MMR-1, HbCV	Completes primary series of DTP and OPV. HbCV can begin up to 60 months if at high risk. Recommended age is 15-23 months.
4-6 Years	DTP-5, OPV-4 MMR-2	MMR-2** can be given at middle school entry, post-secondary entry and to high risk groups as well, except where documentation of immunity is available.***
14-16 Years	Td	Repeat every 10 years.

* Provided at least 6 months have elapsed since DTP-3 or, if fewer than three DTPs have been received, at least 6 weeks since last previous dose of DTP or OPV. MMR vaccine should not be delayed just to allow simultaneous administration with DTP or OPV. Administering MMR at 15 months and DTP-4 and OPV-3 at 18 months continues to be an acceptable alternative.

** Both doses should preferably be given as combined measles, mumps, rubella vaccine (MMR). No less than 1 month apart. If no documentation of any dose of vaccine, vaccine should be given at the time of school entry or employment and no less than 1 month later.

*** Prior physician-diagnosed measles disease, laboratory evidence of measles immunity or birth before 1957.

Prevention and Control of Influenza 1990-91 Season Recommendations of the Immunization Practices Advisory Committee (ACIP)

*Influenza vaccine is strongly recommended for any person 6 months or more of age who, because of age or underlying medical condition, is at increased risk for complications of influenza. Health care workers, others, including household members in close contact with high risk persons, should also be vaccinated. In addition, influenza vaccine may be given to any person who wishes to reduce the chance of becoming infected with influenza.

The tri-valent influenza vaccine prepared for the 1990-91 season will include A/Taiwan/1/86-like (H1N1), A/Shanghai/16/89-like (H3N2), and B/Yamagata/16/88-like hemaglutinin antigens. Recommended doses are listed in Table 1, guidelines for the use of vaccine in different groups follow. Although the current influenza vaccine can contain one or more antigens used in previous years, annual vaccination using the current vaccine is necessary because immunity for an individual declines in the year following vaccination. Because the 1990-91 vaccine differs from the 1989-90 vaccine, supplies of 1989-90 vaccine should not be used to provide protection for the 1990-91 influenza season. Two doses may be required for a satisfactory antibody response in previously unvaccinated children less than 9 years of age. However, studies with vaccines similar to those in current use have shown little or no improvement in antibody responses when a second dose is given to adults during the same season. During the past decade, data on influenza vaccine immunogenicity and side effects have been obtained when vaccine has been administered intra-muscularly. Because there has been no adequate evaluation of recent influenza vaccines administered by other routes, the intra-muscular route is the one recommended for use. Adults and older children should be vaccinated in the deltoid muscle and infants and young children in the anterio-lateral aspect of the thigh.

Because of high risk of influenza related complications in some groups, particular efforts should be directed towards vaccinating the following populations: 1) persons 65 years of age or older; 2) nursing home residents or other chronic care medical facility residents; 3) adults and children with chronic cardio-vascular or pulmonary disorders, including asthma; 4) adults and children with chronic diseases including diabetes mellitus, other metabolic disorders, renal disease or hemoglobinopathies; 5) immune-compromised persons, including persons undergoing immuno-suppressive therapies and persons infected with HIV. Vaccination may produce protective antibodies in many of these people, although antibody response may be inadequate in those more severely infected; and 6) children under 18 years of age receiving long-term aspirin therapy, who could be at risk of developing Reye Syndrome after influenza.

Persons who attend or live with high risk persons should also receive influenza vaccine, in order to reduce the risk of transmission of disease to those at high risk. Such persons include: 1) physicians, nurses and other health care providers who have contact with high risk persons, including infants; 2) employees of nursing homes and chronic care facilities; 3) providers of home care to high risk persons; and 4) those who live in households of high risk persons.

Influenza vaccinations are best performed each year in the fall before disease activity becomes wide spread. Cases of influenza in Montana occur most often between end of November and April. The optimum time in which to immunize high risk groups is usually the beginning of November, although vaccination can begin in late October. Substantially earlier vaccinations may not provide adequate protection throughout the entire influenza season.

*Centers for Disease Control, Prevention and Control of Influenza: Recommendations of the Immunization Practices Advisory Committee (ACIP). Morbidity and Mortality Weekly Report, 1990: 39(rr-7).

MONTANA
RESIDENT AND NON-RESIDENT AIDS CASES*
Acquired Immunodeficiency Syndrome (AIDS)
Definitive and Presumptive AIDS Cases
Surveillance Report - 7/1/90 to 7/31/90

1. Disease Category	Adult/Adolescent Cases (%)	Deaths (%)
PCP	30 (47)	20 (67)
Other Disease w/o PCP	32 (50)	20 (66)
KS Alone	2 (3)	0 (0)
No Diseases Listed	0 (0)	0 (0)
Total	64 (100)	40 (63)

2. Age	Cases (%)
Under 13	0 (0)
13-19	1 (2)
20-29	19 (30)
30-39	28 (44)
40-49	10 (16)
Over 49	6 (9)
Unknown	0 (0)
Total	64 (100)

3. Race/Ethnicity	Adult/Adolescent Cases (%)
White, Not Hispanic	57 (89)
Black, Not Hispanic	1 (2)
Hispanic	2 (3)
Native American	4 (6)
Unknown	0 (0)
Total	64 (100)

4. Exposure Category	Adult/Adolescent Males (%)	Females (%)	Total (%)
Homosexual or Bisexual Men	38 (59)	0 (0)	38 (59)
Intravenous (IV) Drug User	6 (9)	0 (0)	6 (9)
Homo/Bi IV Drug User	7 (11)	0 (0)	7 (11)
Hemophiliac	3 (5)	0 (0)	3 (5)
Heterosexual Contact	0 (0)	4 (6)	4 (6)
Transfusion With Blood/ Products	0 (0)	1 (2)	1 (2)
None of the Above/Other	4 (6)	1 (2)	5 (8)
Total	58 (90)	6 (10)	64 (100)

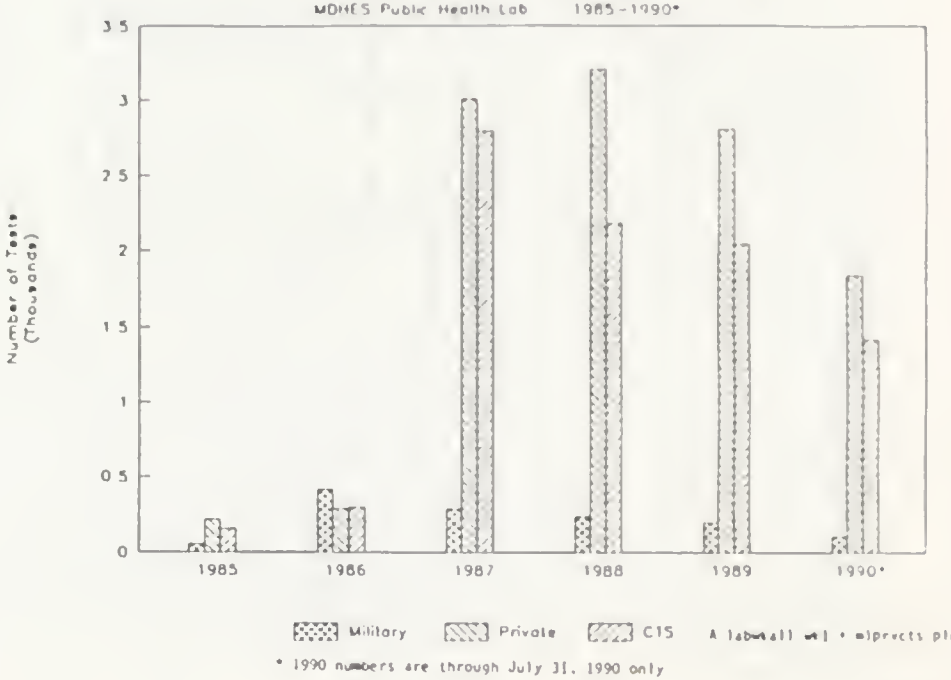
Source: Montana AIDS/STD Program, MDHES, through July 31, 1990.

*Includes 47 Montana AIDS cases and 16 cases reported to Centers for Disease Control from other states who moved to Montana.

As of July 31, 1990 there have been 260 positive HIV tests from 21,585 cumulative tests conducted through the MDHES Public Health Laboratory.

Nationally, as of June 30, 1990, 139,765 cases of AIDS and 85,430 deaths have been reported to the Centers for Disease Control.

HIV ANTIBODY TESTING - MONTANA



Class Offering

The Montana Department of Health and Environmental Sciences, AIDS Program, announces a date for the next HIV counselor course. The course will be offered October 10-11, 1990 in either Bozeman or Billings. This course is being offered to provide training for people involved in counseling persons who request the HIV test. For more information, call Kathy Andersen or Rhonda Forrette at 444-4740.

JULY 1990	Campylobacter, diarrhea	Chlamydia, sexually transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non B	Hepatitis, unspecified	Meningococcal meningitis	Post exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead		2													
Big Horn		5											2		
Blaine		1					1								
Broadwater		1													
Carbon		2		1											
Carter															
Cascade		10		2							4		1		
Chouteau											1	1			
Custer		2											1		
Daniels															
Dawson	2														
Deer Lodge			5												
Fallon															
Fergus		2	4												
Flathead	2	1	3	1	2		2				2		4		
Gallatin		10		1							1				
Garfield														1	
Glacier		3				2	1								
Golden Valley															
Granite															
Hill	1	16	1												
Jefferson															
Judith Basin				2											
Lake		3													
Lewis & Clark	1	7	3			2				1					
Liberty															
Lincoln		2		1							1				
McCone															
Madison			1												
Meagher															
Mineral															
Missoula	5	6	2							1	2	3			
Musselshell															
Park		1											1		
Petroleum															
Phillips		1													
Pondera						1									
Powder River											1				
Powell		1													
Prairie															
Ravalli		6													
Richland		1											1		
Roosevelt		5	1				-							3	
Rosebud		2		2							1				
Sanders															
Sheridan															
Silver Bow		9				1	1	1					2		
Stillwater				1											
Sweet Grass															
Teton		1										1			
Toole															
Treasure															
Valley												1			
Wheatland															
Wibaux															
Yellowstone	3	35		13				1					1		
MONTHLY TOTAL 1990	14	135	20	24	2	6	5	2	0	2	13	6	13	4	0
MONTHLY TOTAL 1989	17	110	18	14	1	7	8	1	1	0	15	10	17	3	4
MONTHLY TOTAL 1988	17	141	19	41	0	4	2	1	0	1	14	15	12	47	0
TOTAL TO DATE 1990	60	897	91	123	8	67	43	4	4	10	47	32	64	26	10
TOTAL TO DATE 1989	46	803	71	120	5	34	33	3	2	1	50	55	36	69	12
TOTAL TO DATE 1988	40	1191	100	262	6	25	33	8	3	1	47	143	44	91	5

OTHER DISEASES: Aseptic mening: Yellowstone-1
Cyto-megalo-viral Illn: Cascade-1, Gallatin-1
Mumps: Flathead-1
Rocky Mtn Spotd Fever: Yellowstone-1
Chickenpox: Cascade-1, Gallatin-1, Powell-1
Legionellosis: Flathead-1
Pertussis: Ravalli-3
Yersinia Entero: Flathead-2

AN OPEN LETTER TO HEALTH PROFESSIONALS

Health care professionals have a responsibility to provide services designed to optimize the health of their clients. Breastfeeding has been well-documented as the optimal way to nurture infants and to provide important benefits for the mother.

To help expectant mothers make informed decisions regarding the choice of feeding for their infants, it shall be the policy of the Montana Department of Health and Environmental Sciences to support and promote the education of women and the public in the values of breastfeeding.

This policy is consistent with the Congressional mandate to WIC to aggressively promote breastfeeding. Promotion of the values of breastfeeding is consistent with the National Health Objectives for the Year 2000. It also has the endorsement of the American Academy of Pediatrics, the American Public Health Association, the American Dietetic Association and the National Association of WIC Directors.

The Montana Department of Health and Environmental Sciences encourages activities which promote and protect the health of all Montana children. Breastfeeding support, education and promotion has long been a goal of the Montana WIC Program.

If you have questions or would like more information, contact the WIC Program in your community or the State WIC Office (444-4740).

Sincerely yours,

Donald E. Pizzini
Director

Volume: 14-7 **Month of:** JULY 1990

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Vol. 14-8 AUGUST 1990

Montana State Department of Health and Environmental Sciences

Hepatitis A at Montana Developmental Center in Boulder

As of September 5, 1990, 31 cases of Hepatitis A in residents at Montana Developmental Center (MDC) have been confirmed by laboratory testing. Two cases in workers at the Center have also occurred. Cases were first suspected during the end of July when several residents displayed symptoms of Hepatitis A. Montana Department of Health and Environmental Sciences was consulted and they invited Centers for Disease Control, Hepatitis Branch staff to the MDC for epidemiologic investigation and control recommendations.

After extensive epidemiologic investigation, Centers for Disease Control staff determined the outbreak appeared to be from a point source. Cases onsets were clustered around the first week of August. Interviews of residents and staff eliminated some possible means of transmission and began to make other means more likely sources. Desserts were finally determined to be a risk factor for the one staff member and the original thirteen cases of Hepatitis A. On further exploring, consumption of strawberries in desserts was found to be a risk factor.

The menu at MDC is repeated on a three-week rotating basis. Strawberries are used in several dishes, one of which is uncooked. Any fresh or fresh-frozen fruit or vegetable has the potential for being contaminated with Hepatitis A virus. Hepatitis A virus will withstand freezing for as long as five years.

The Centers for Disease Control investigators were aware of their branch participating in a Hepatitis A outbreak in a Georgia elementary school during April and May of 1990. At that time, consumption of frozen strawberries in the school lunch program appeared to be a risk factor for Hepatitis A. Upon closer inspection it was found the strawberries used at the elementary school and the strawberries used at Montana Developmental Center had similar lot code numbers. This, while not being conclusive, did improve the chance the strawberries were implicated.

The strawberries were packaged in 30-pound containers and distributed to institutions. The product was a sliced strawberry with sugar added. The lot of strawberries in question was not available to the general public or in any other manner than the one just described -- 30-pound frozen tubs. Therefore, tracking of the suspect product from the local distributor was possible and begun. In some instances, strawberries had been moved from their original containers into smaller vessels and therefore determining whether or not they were from the suspect lot was impossible, but for the most part, the lot in question was accounted for in Montana. There was a large amount of the suspect lot found unused and it has been shipped to Centers for Disease Control for an attempt to isolate virus. It is not likely virus will be recovered from the berries.

Centers for Disease Control has isolated virus from the stools of persons diagnosed as having Hepatitis A at Montana Developmental Center. It will be subjected to testing to determine whether the type of Hepatitis A virus at the Developmental Center is similar to the one isolated in the Georgia elementary school. This again would improve the assumption the strawberries were infected with Hepatitis A virus and were the source of infection at Montana Developmental Center.

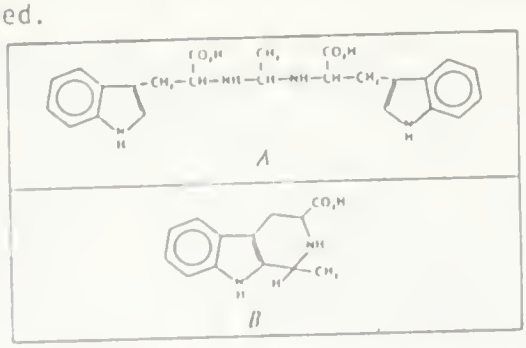
Analysis of L-Tryptophan for the Etiology of Eosinophilia-Myalgia Syndrome

Eosinophilia-myalgia syndrome (EMS)has been associated with consumption of L-tryptophan-containing products (LTCPs) and most strongly associated with consumption of LTCPs produced by one manufacturer. Epidemiologic and laboratory investigations have suggested that the implicated LTCPs were contaminated. To further examine this hypothesis, CDC and the Food and Drug Administration (FDA) conducted additional laboratory studies. This report summarizes preliminary data that indicate that implicated LTCPS were contaminated with the di-tryptophan aminal of acetaldehyde (DTAA).

The laboratory investigation determined that case-associated with L-tryptophan (LT) cultures were negative for bacteria and viruses and that endotoxin levels were not elevated in case-associated LT. Analysis of case-associated LT for 37 elements identified none at toxicologically significant concentrations.

Fifty lots of LT produced between March 1985 and June 1989 by the implicated manufacturer were analyzed by high-performance liquid chromatography (HPLC). Thirteen lots were linked to EMS cases; other lots were considered as controls because no link with cases could be identified. Several HPLC peaks (called peaks 97, 100 and 200) were identified that were predictive of case-associated LT lots. Amounts of peak 97 in LT lots from the implicated manufacturer increased dramatically between March and June 1989.

In addition to peaks 97,100 and 200, ongoing investigation is directed at 1-methyl-1,2,3,4-tetrahydro-β-carboline-3-carboxylic acid (MTCA) and bacitracin, detected in LT lots from the implicated manufacturer. MTCA could be produced from the breakdown of DTAA or independently formed.



A. D-L tryptophan aminal of acetaldehyde (proposed structure for Peak 97)
B. 1-Methyl-1, 2, 3, 4-tetrahydro-β-carboline-3-carboxylic acid

The epidemiologic association of peak 97 and any other particular compound with EMS indicates that these compounds may either be the causative agent(s) or marker(s) for a different, as yet unidentified, causative agent in case-associated LT lots. Based on an average daily dose of 2 g of LT for a 70-kg person and a 30-day delay before onset of EMS, the total dose of peak 97 is approximately 90 μg/kg. The toxic properties of the aminals are not well defined; however, the suspected decomposition products, the β-carbolines, exhibit a variety of biologic properties.

The full definition of biologic and toxic effects of the contaminants can be determined only in an animal model for EMS. A joint National Institute of Mental Health/National Institutes of Health/FDA/CDC study has recently reproduced EMS-like changes in rats (E.M. Sternberg, personal communication). Synthesizing these contaminants and testing them in the new rat model may help to clarify their relationship to the etiology and pathogenesis of EMS. Continuing studies include analyzing additional LT lots, identifying and synthesizing contaminants and attempting to associate changes in the manufacturing process with these contaminants.

(Greater detail may be found in MMWR; Vol. 39, No.34, August 31, 1990)

Update: Eosinophilia-Myalgia Syndrome Associated with Ingestion of L-Tryptophan - United States, through August 24, 1990

As of August 24, 1990, 1,536 cases of eosinophilia-myalgia syndrome (EMS) had been reported to CDC from all 50 states, the District of Columbia and Puerto Rico (Figure 1). Twenty-seven deaths have been reported in patients who met the surveillance case definition and who used L-tryptophan-containing products (LTCPs).

As of August 24, CDC had received 1,117 completed report forms from state and territorial health departments. Ages of patients ranged from 4 years to 85 years (median: 48 years); 1,046 (94%) of the patients were non-Hispanic white, 19 (2%) were Hispanic, 12 (1%) were black and 40 (4%) were from other or unknown racial/ethnic groups; and 930 (83%) were female. 1,068 (96%) patients had histories of LTCP ingestion preceding onset of symptoms. Symptom onset during or after July 1989 was reported in 946 (85%). Eight (0.7%) patients had onset on or after February 1, 1990. 360 (32%) patients had

been hospitalized for their illnesses by the time the cases were reported.

On November 17, 1989, the Food and Drug Administration (FDA) recalled all dietary supplements that provided a daily dose of L-tryptophan (LT) more than 100 mg. By March 22, 1990, this recall had been expanded to include all LTCPs at any dosage except some protein supplements, infant formulas and special dietary foods, and intravenous and oral solutions in which small amounts of LT are needed for nutrient fortification.

The eight EMS cases reported with onset after February 1 appear to have resulted principally from continued use of LT by some persons after the FDA recall rather than from long disease latency following cessation of LTCP exposure. One patient began use of LTCPs on March 20, 1990 and became ill 1 month later, indicating that some persons may be unaware of, or choose to ignore the FDA recall.

National surveillance figures do not fully reflect the proportion of patients ultimately hospitalized as a result of EMS. Because each case is reported only once, information regarding hospitalization of patients requiring admission after their cases are reported is not available.

The surveillance definition for reporting EMS cases to CDC requires the presence of severe, debilitation myalgias and eosinophilia more than 1,000 eosinophils per mm^3. Recent unpublished reports indicate that this case definition may be overly restrictive for clinic purposes. Many persons may have forms of EMS that are either less severe or in which the constellation of clinical findings does not include the intense eosinophilia or severe myalgias initially identified as the hallmarks of epidemic EMS. Thus far, such cases have not been the object of national surveillance.

The failure of a case to meet criteria specified in the surveillance definition does not preclude a clinical diagnosis of EMS in a person who manifests other features of EMS or who has either a lower eosinophil count or milder myalgias. As in other diseases with multiple connective tissue manifestations, a set of clear-cut diagnostic criteria with both high sensitivity and specificity may be difficult or impossible to establish. The physician's judgment and appropriate weighing of all available information are important in the clinic diagnosis of EMS.

Important Information Forms, Clinic Signature Cards and Signature Log Sheets Affected by Immunization Documentation Requirements Change

Effective Date: January 1, 1991

The federal government has initiated a change in the information which is required to be documented for each immunization given when project funds are used. This change will affect Important Information Forms, Clinic Signature Cards, and Signature Log Sheets used by clinics to document immunization information.
Any other addition to the documents or variations from the language or format of them, must have the prior written approval of the Director, Center for Prevention Services, Centers for Disease Control. The DHES will forward these requests to CDC.

At a minimum, the following information must be documented for each immunization: (Those areas which are new additions or are changed from the previous requirement, are indicated by an asterisk)

1) * The following statement will appear at the top of the signature card or log sheet: "I have read or have had read to me the information contained in the Important Information Statement(s) or Vaccine Information Pamphlets(s) about the disease(s) and the vaccine(s). I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated below be given to me or to the person named below for whom I am authorized to make this request."

2) Client's Name, address, date of birth, and age at the time they are being immunized.

3) Type(s) of vaccine(s).

4) *Clinic/office address.

5) Date of Immunization.

6) Manufacturer and lot number.

7) Signature of person to receive vaccine or the person authorized to make the request; date of the signature.

8) *Signature and title of person administering vaccine.

9) The date printed on the appropriate "Important Information Statement" or "Vaccine Information Pamphlets".

The Montana Immunization Program will continue to provide Clinic Signature Cards for documenting the above information. Earlier this year, there was an attempt made, by the program, to redesign the card. Some of the comments from the field included changes which are outside of what is acceptable to meet the federal requirements. For example, there were several requests to remove the form/date, sign/date, and age sections, which are mandatory.

Plan on Expanding Your Clinic Signature Card File or Signature Log Sheet

All immunization documentation, including parent signatures must continue to be maintained. Clinic immunization records for children who have had previous immunizations at your clinic and come in for additional immunization will probably have at least two separate records showing the parents' signature (the old card or log sheet and the new version).

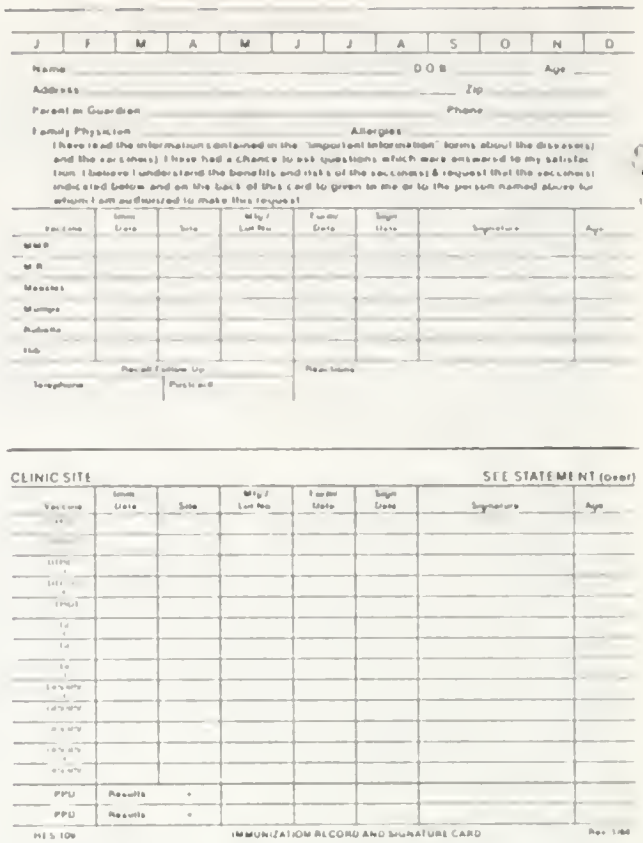
In the case where the Clinic Signature Card or an individual Signature Log Sheet is used, including the revised cards or log sheets may double the space needed to maintain immunization information on some clients. It is recommended that the new and old records be attached together (stapled). This may make it necessary to expand your file.

If your clinic is not maintaining an open file for children who are currently being immunized for their primary series, it may be useful to do so at this time to reduce the amount of records to sort through to find an individual card.

Clinic Signature Card Comments Requested

The Montana Immunization Program requests your input/comments on how to revise the card, maintain it at it's current size to fit into majority of the public clinic's card filing systems, meet the federal requirements, and make it usable for both the parent and the clinician. Comments received earlier, regarding possible changes to the card, were appreciated and will be still considered in the new revision.

The following is a copy of the current Clinic Signature Card. Please send comments to:


J F M A M J J A S O N D

Name DOB Age

Address Zip

Parent or Guardian Phone

Family Physician Allergies

I have read the information contained in the "Important Information" forms about the disease(s) and the vaccine(s). I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) & request that the vaccine(s) indicated below and on the back of this card be given to me or to the person named above for whom I am authorized to make this request.

Vaccine | Given Date | Site | Mfg / Lot No. | Expir Date | Sign Date | Signature | Age

MMR

MR

Measles

Mumps

Rubella

Hib

Parent Follow Up Reactions

Telephone Postcard

CLINIC SITE SEE STATEMENT (back)

Vaccine | Given Date | Site | Mfg / Lot No. | Expir Date | Sign Date | Signature | Age

PPD Results

PPD Results

MES 109 IMMUNIZATION RECORD AND SIGNATURE CARD Rev. 1/88

The Montana Immunization Program
Montana Department of Health and Environmental Sciences
Cogswell Building
Helena, MT 59620

FIELD HEALTH OFFICER

Paul Lamphier, MT (ASCP), has recently joined the staff of the AIDS/STD Program. Paul will function as the Field Health Officers and will coordinate the STD intervention activity. He will work with local health departments to ensure interviews of all cases of syphilis, gonorrhea and chlamydia. In addition, he will provide training in interviewing techniques and contact investigation to local health department personnel.

Paul has been employed in laboratory medicine since 1962 and most recently employed by the Public Health Laboratory, Montana Department of Health and Environmental Sciences. In addition to his work in STD intervention, he plans consultative revisitation of all Montana laboratories performing diagnostic procedures for STD.

Paul can be reached at 444-4740.

AUGUST 1990	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead		2													
Big Horn		2		1											
Blaine		3				1									1
Broadwater															
Carbon		3									1				
Carter															
Cascade		21		2							1				1
Chouteau											1				
Custer		1									1	1			
Daniels															
Dawson															
Deer Lodge		1													
Fallon															
Fergus		1	2												
Flathead		7	3				1				1		1	1	4
Gallatin		9	2	1											
Garfield															
Glacier		6				2					1				
Golden Valley															
Granite															
Hill		8	1												1
Jefferson		1				7									
Judith Basin				1		2									
Lake		8													
Lewis & Clark	1	11	1				1				1	1			1
Liberty															
Lincoln				1											
McCone															
Madison															
Meegher															
Mineral															1
Missoula		14	1	1		1					1		1		
Musselshell		1										1			
Park		4		1								1			
Petroleum															
Phillips															
Pondera															
Powder River															
Powell															
Prairie															
Ravalli		4		1							1				
Richland		1													
Roosevelt		2		1										1	3
Rosebud		1		4							1		3		
Sanders															
Sheridan															
Silver Bow	3	6		1	1	1	1						3		
Stillwater		1										1			
Sweet Grass												1			
Teton															
Toole						1									
Treasure															
Valley		1													
Wheatland															
Wibaux															
Yellowstone	1	35		10		5	2	1					1	1	1
MONTHLY TOTAL 19 90	5	154	10	25	1	20	5	1	0	0	11	7	9	3	12
MONTHLY TOTAL 19 89	21	104	24	19	2	11	4	2	0	0	17	7	11	4	0
MONTHLY TOTAL 19 88	10	170	21	27	1	1	5	1	0	0	9	17	18	36	7
TOTAL TO DATE 19	65	1051	101	148	9	87	48	5	4	10	58	39	73	29	18
TOTAL TO DATE 19	46	803	71	120	5	31	33	3	2	1	50	55	36	89	12
TOTAL TO DATE 19	40	1191	100	262	6	25	33	8	3	1	47	143	44	91	5

OTHER DISEASES:

ASEPTIC MENING: Stillwater - 1

BACTERIAL MENING UNPSEC: Gallatin - 1, Missoula - 1

CHICKENPOX: Cascade - 2; Silverbow - 1

COLORADO TICK FV.: Beaverhead - 2, Big Horn - 1

YERSINIA ENTERO: Pondera - 1

Stipends Available for HIV Counseling Course

The Montana AIDS/STD Program is sponsoring a course entitled "HIV Counseling Techniques" to be held in Bozeman at the Holiday In,, October 10-11, 1990. The purpose of the course is to ensure that persons receiving HIV antibody tests are appropriately counseled and provided accurate information.

The AIDS/STD Program has a limited number of stipends to support travel, lodging and meal costs (at state rates). We are offering assistance to those who otherwise would be unable to attend. If you or someone you know would like to apply, please send a letter to the program requesting assistance. All requests must include name of employer, name and title of person attending, amount being requested and how the skills learned will be applied in your community. Please notify us by September 28th.

If you have any questions or comments about the course, please call Rhonda Forrette or Kathy Andersen at 444-4740.

Class Offering

The Montana Department of Health and Environmental Sciences' AIDS Program announces a date for the next HIV counselor course. It will be held at the Holiday Inn in Bozeman on October 10-11, 1990. The course is offered to provide training for people involved in counseling persons who request the HIV test. For more information and/or registration, call Kathy Andersen or Rhonda Forrette at 444-4740. Please note that enrollment is limited to 21 people; the deadline for registration is September 28.

TABLE I. Summary – cases of specified notifiable diseases, United States, cumulative, week ending August 11, 1990 (32nd Week)

	Cum. 1990		Cum. 1990
AIDS	25 917	Plague	1
Anthrax		Poliomyelitis, Paralytic*	1
Botulism: Foodborne	4	Psittacosis	78
Infant	36	Rabies, human	1
Other	5	Syphilis: civilian	29 299
Brucellosis	43	military	160
Cholera	2	Syphilis, congenital, age < 1 year	65
Congenital rubella syndrome	2	Tetanus	35
Diphtheria	1	Toxic shock syndrome	254
Encephalitis, post infectious	82	Trichinosis	19
Gonorrhea: civilian	401 395	Tuberculosis	13 136
military	5 527	Tularemia	66
Leprosy	127	Typhoid fever	243
Leptospirosis	28	Typhus fever, tickborne (RMSF)	338
Measles: imported	804		
indigenous	18 527		

*Three cases of suspected poliomyelitis have been reported in 1990. Five of 13 suspected cases in 1989 were confirmed and all were vaccine associated.

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VOL. 14-9 SEPTEMBER, 1990

Montana State Department of Health and Environmental Sciences

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Treatment of Gonococcal Infections

Treatment of gonococcal infections in the United States is influenced by the following trends: 1) the spread of infections due to antibiotic-resistant N. gonorrhoea, including penicillinase-producing N. gonorrhoea (PPNG), tetracycline-resistant N. gonorrhoea (TRNG), and strains with chromosomally mediated resistance to multiple antibiotics; 2) the high frequency of chlamydial infections in persons with gonorrhea; 3) recognition of the serious complications of chlamydial and gonococcal infections; and 4) the absence of a fast, inexpensive, and highly accurate test for chlamydial infection.

All gonorrhea cases should be diagnosed or confirmed by culture to facilitate antimicrobial susceptibility testing. The susceptibility of N. gonorrhoea to antibiotics is likely to change over time in any locality. Therefore, gonorrhea control programs should include a system of regular antibiotic sensitivity testing of a surveillance sample of N. gonorrhoea isolates as well as all isolates associated with treatment failure.

Single-dose efficacy is a major consideration in choosing an antibiotic regimen to treat persons infected with N. gonorrhoea. Another important concern is coexisting chlamydial infection, documented in up to 45% of gonorrhea cases in some populations. Until universal testing for chlamydia with quick, inexpensive, and highly accurate tests becomes available, persons with gonorrhea should also be treated for presumptive chlamydial infections. Generally, patients with gonorrhea infections should be treated simultaneously with antibiotics effective against both C. trachomatis and N. gonorrhoea. Simultaneous treatment may lessen the possibility of treatment failure due to antibiotic resistance.

Recommended Regimen

> Ceftriaxone 250 mg IM once, plus
> Doxycycline 100 mg orally 2 times a day for 7 days.

Some authorities prefer a dose of 125 mg ceftriaxone IM because it is less expensive and can be given in a volume of only 0.5 ml, which is more easily administered in the deltoid muscle. However, the 250-mg dose is recommended because it may delay the emergency of ceftriaxone-resistant strains. At this time, both doses appear highly effective for mucosal gonorrhea at all sites.

Because of the wide spectrum of anti-

microbial therapies effective against N. gonorrhoea, these guidelines are not intended to be a comprehensive list of all possible treatment regimens.

Treatment failure following combined ceftriaxone/doxycycline therapy is rare; therefore, a follow-up culture ("test-of-cure") is not essential. A more cost-effective strategy may be a re-examination with culture 1-2 months after treatment "re-screening"); this strategy detects both treatment failures and re-infections. Patients should return for examination if symptoms persist after treatment. Because there is less long-term experience with drugs other than ceftriaxone, patients treated with regimens other than ceftriaxone/doxycycline should have follow-up cultures obtained for 4-7 days after completion of therapy.

Reference: Sexually Transmitted Diseases Treatment Guidelines (September 1990) Centers for Disease Control, Public Health Service.

Increase in Enteric Diseases

Compared to this time last year, reported cases of campylobacter, giardiasis, hepatitis A, salmonellosis are up from last year. No one specific cause of this increase has been identified. The Hepatitis A outbreak at Boulder, of course, contributed to the increase in those cases. Campylobacteriosis has been increasingly recognized as an important cause of enteritis in pediatric and adult populations for the past ten years. Campylobacteriosis is probably as common as salmonellosis although not reported as frequently because testing is not done specifically for detecting it. Campylobacter jejuni is the species most often causing human pathogenesis. Campylobacter enteritis is an acute infectious gastro-enteritis found year round but more frequently in the summer months. The infective dose of the organism is low and the illness has an incubation period of one to ten days. Typically there is acute onset of profuse mucoid, often bloody diarrhea, severe abdominal pain and cramps, fever, chills, malaise and headache. The illness is usually self limited though up to 25% of persons may have recurrence of symptoms and persistent organisms in the stool for up to 7 weeks. The epidemiology of Campylobacter fetus ssp jejuni enteritis is not well known the organism is frequently isolated from cows and chickens and has been isolated in diarrheal stools of kittens and puppies. Human infection is from milk, contaminated water, recently butchered chickens, puppies, kittens, monkeys and cows. Human to human transmission probably occurs.

Giardia lamblia is the cause of significant acute and chronic diarrheal illness. Person to person spread through ingestion of cysts is probably the most important mode of transmission but food and water borne transmission have been documented. The organism may infect a number of animals including dogs, cats, beavers and muskrats but their role in infecting humans is unclear.

Symptoms may be acute, intermittent or chronic and include bloating, abdominal cramps, headache and occasional fever.

Giardiasis may be a cause of steatorrhea and malabsorption and failure to thrive in young children. The most significant risk factor for giardiasis in adults is having a child or infant in the household, drinking untreated water and foreign travel.

Surveillance for enteric disease has traditionally been done to promote disease prevention and achieve control. Early identification and removal of contaminated products from the commercial market, correction of faulty food preparation practices in food service establishments and the home and identification and appropriate treatment of human carriers of food borne pathogens are the fundamental prevention and control measures.

The responsible pathogen was not identified in over half of food borne disease outbreaks reported to CDC in five years' time. In others, the responsible pathogen may have escaped detection even when a thorough laboratory investigation was carried out.

Regardless of the cause of diarrheal illness, precautions for prevention of transmission should be instituted at the onset of diarrhea. The organism causing the diarrheal illness should be searched for via stool specimens. Submission of specimens for various testing must be done

on appropriate media. For example, specimens to be tested for giardia must be submitted in a manner different than specimens submitted for salmonella testing.

Prevention for spread of diarrheal illness includes the following measures: (1)Thorough handwashing four to six times a day, particularly after using the toilet and before preparing food for others. Hands should be washed after changing diapers. (2) Poultry and meat should be thoroughly cooked. (3) Food sources which are eaten raw should be washed and rubbed under running water to remove organisms. (4) Surfaces used in preparing raw poultry and meat items should be thoroughly cleaned before further use. (5) Raw milk and other unpasteurized dairy products should not be used. (6) Persons should not drink untreated water or water where the status is unknown. (7) Care should be taken with animal droppings to avoid contact or inhalation of them. (8) If in contact with someone with diarrhea, the contact should consult public health professionals or their private physician to see if there are preventive measures that might be taken such as the administration of immune serum globulin for Hepatitis A prevention.

While enteric diseases are usually not life threatening for healthy people, they can be of serious consequence and have adverse outcomes for the very young, the very elderly or the debilitated. A concerted effort at preventing transmission of enteric diseases can be done through educational campaigns at a very minimal cost.

---

* *
* HIV/AIDS INFORMATION *
* *

Prevalence of HIV-1 Antibody in Civilian Applicants for Military Service

Since October 1985, all persons applying for active military duty or reserve military service, the service academies, and the reserve officer training corps have been screened for HIV infection as part of their entrance medical evaluation. Military applicants are interviewed by recruiting officials about drug use and homosexual activity before referral for medical evaluation. Potential applicants are informed that they will be screened for HIV antibody. It is expected that IV drug users and homosexual men are under-represented among military applicants who are medically evaluated. Demographic data shared with CDC include the applicant's age, sex and race and reported home of record (state and county).

Of the 2,740,265 applicants screened between October 1985 through June of 1990 there have been 3,300 positives reported for a seroprevalence rate of 0.12%. During that same period of time, 14,654 applicants from Montana have been screened with two positives, for a positivity rate of 0.01%. Of those Montana applicants, 12,461, or 85%, have been male. 13,558, or 92%, have been white. 829 or 5.7% have been American Indian or Alaskan. 242 or 1.7% have been Black, Hispanic or of Asian descent. Montana's two positive applicants have been in the age group 20-24 and 30 and older.

In addition, the Montana Public Health Laboratory has screened 1,331 applicants through August 31, 1990 with no positives reported.

HRSA to Fund HIV Services

The Montana Department of Health and Environmental Sciences has applied for a $100,000 grant from the Health Resources and Services Administration (DHHS) to provide funds for home and community based services for people chronically or medically dependent due to HIV/AIDS.

If awarded DHES will subcontract 97.5% of the grant to an agency for a one year contract beginning as early as November 1990. Services covered under the program will include durable medical equipment; homemaker/home health aide services and personal care services; day treatment or other partial hospitalization services; home intravenous drug therapy; and routine diagnostic tests.

For further information, contact Bruce Desonia, AIDS/STD Program Manager at 444-4740.

Revised CDC Requirements for Content of HIV/AIDS-Related Educational Materials

Following public comment, the Centers for Disease Control has issued revised guidelines concerning the content of HIV/AIDS-related written materials, pictorials, audiovisuals, questionnaires, survey instruments, and educational sessions, dated 6/90.

Some of the provisions of the guidelines are that:

-- Written materials, audiovisual materials, and pictorials should not include terms, descriptors, or displays which will be offensive to a majority of the intended audience or to a majority of adults outside the intended audience unless, in the judgement of the Program Review Panel, the potential offensiveness of such materials is outweighed by the potential effectiveness in communicating an important HIV prevention message.

-- The Surgeon General's Report on AIDS (October 1986) and CDC-developed materials do not need to be reviewed by the panel unless such review is deemed appropriate by the recipient.

-- Because Program Review Panels review materials for many intended audiences, no single intended audience shall predominate the composition of the Program Review Panel. However, panels reviewing materials intended for racial and ethnic minority populations may be drawn from such racial and ethnic populations. Recipients are encouraged to use consultants to augment the expertise of Program Review Panels on particular matters.

All MDHES HIV/AIDS contractors have been provided with a copy of the revised document. Questions concerning the implementation of the guidelines should be directed to Kathy Andersen, AIDS Review Panel Chair at 444-4740.

WORLD AIDS DAY
Saturday, December 1, 1990

On December 1, 1990, the United States and more than 150 countries around the world will take part in the third annual observance of World AIDS Day, sponsored by the World Health Organization (WHO).

Along with increasing awareness about HIV, the virus that causes AIDS, and preventing it from spreading, the purpose of World AIDS Day is to bring a message of compassion, hope and understanding about the disease to people everywhere.

The theme for this year's World AIDS Day is "Women and AIDS". WHO estimates two million women are infected with HIV worldwide and that during the 1980's, up to 200,000 infants became HIV infected through perinatal transmission. In Montana, between January, 1989 and September 30, 1990, there have been 90 positive HIV tests; of these, seven have been for women. Additionally, of the 67 cases of AIDS, seven cases are women.

Along with an emphasis on women with HIV infection and AIDS, the theme also recognizes the importance of women in preventing HIV infection and caring for people with AIDS.

You can help increase the worldwide perspective on HIV infection and AIDS in Montana by sponsoring an activity in your community. Your emphasis can be on prevention, promoting care for people with AIDS or preventing discrimination against people with HIV infection and AIDS.

World AIDS Day is observed by all types of people and organizations such as elementary and high school students, colleges, local governments, hospitals, health clinics, religious groups, civic organizations, companies and the media -- anyone who is concerned about how this disease is affecting each of us on a global scale.

If you would like to participate, you can order a World AIDS Day Action Kit from the American Association for World Health. The address is:

American Association for World Health
2001 S Street NW
Suite 530
Washington, DC 20009

The kit includes a 30 page guidebook

containing information, a World AIDS Day poster, activity suggestions, sample materials, lesson plan suggestions and a special resource section. Only one kit can be sent per request.

Thanks for making World AIDS Day a success in Montana!! For any further information, contact Kathy Andersen at the AIDS/STD Program at 444-4740.

The Sixth Annual Rocky Mountain Regional

Conference on AIDS

Friday, January 11, 1991

8:00a.m. **Registration**

8:30a.m. **Welcome:**
Terry Stewart, Director of Education
Colorado AIDS Project
Donna Anderson, Ph.D., Project Coordinator
Colorado AIDS Education and Training Center
Peter Ralin, M.S., Director,
AIDS Information Service
Denver Department of Public Health

8:45a.m. **Social Change and HIV Transmission**
Mindy Fullilove, M.D.
Principal Investigator of the Substance Abuse CORE
HIV Center for Clinical and Behavioral Studies
New York State Psychiatric Institute and
Columbia University

9:30a.m. **HIV/AIDS in the Rocky Mountain Region**
Fred Wolf, M.P.A.
Section Chief, STD/AIDS Control
Colorado Department of Health

10:15a.m. **Break**

10:45a.m. **Workshops I**

12:00p.m. **Lunch** (On your own)

1:30p.m. *CONCURRENT GENERAL SESSIONS:*
HIV/AIDS and People of Color: Tomorrow's Challenge Today
Rashidah Hassan
Co-Founder and Executive Director of Bebashi
Treatments in the Making:
AIDS Clinical Trial Groups (ACTG)
Community Programs for Clinical Research on AIDS (CPCRA)

2:15p.m. **Workshops II**

3:30p.m. **Break**

3:45p.m. **Early Intervention in HIV Disease**
Martin Delaney
Executive Director, Project Inform

4:30p.m. **End of Day I**

Saturday, January 12, 1991

8:30a.m. **Pediatric AIDS: Current Status and Impact**
Ciro Sumaya, M.D., M.P.H.
Division Head, Pediatric Infectious Diseases
University of Texas Health Sciences Center

9:15a.m. **Workshops III**

10:30a.m. **Break**

11:00a.m. *CONCURRENT GENERAL SESSIONS:*
Promises and Challenges of HIV/AIDS Prevention Education
Jacqueline G. Sowers, Ph.D.
Partner, Sowers Associates
Management of Opportunistic Infections
David Cohn, M.D.
Director, Denver Disease Control Service

12:00p.m. **Luncheon (Optional; $15.00)**
Speaker: Sallie Perryman
Special Assistant, Director of Policy
AIDS Institute for New York State
Topic: Perspectives of an HIV Positive Woman

1:30p.m. *CONCURRENT GENERAL SESSIONS:*
Clinical Manifestations
David Cohn, M.D.
Director, Denver Disease Control Service
Handling Opposition to HIV Education
Jacqueline G. Sowers, Ph.D.
Partner, Sowers Associates

2:15p.m. *CONCURRENT GENERAL SESSIONS:*
Treatment Update
Robert "Chip" Schooley, M.D.
Head, Division of Infectious Diseases
University of Colorado Health Sciences Center
Reaching High Risk Individuals
Centers for Disease Control,
National AIDS Information & Education Program

3:00p.m. **Break**

3:15p.m. **Workshops IV**

4:30p.m. **Relapses, Resources, and Reassessments: Construction of a Starship for an Unknown Galaxy**
Rev. Julian Rush, M. Div., S.T.M., M.A.
Executive Director, Colorado AIDS Project

5:15p.m. **End of Conference**

REGISTRATION FORM

Please enroll me in the Sixth Annual Rocky Mountain Regional Conference on AIDS, January 11-12, 1991.

Name _____ Organization _____

Street _____ City, State, Zip _____

Phone _____ Current Position _____

Specialty _____ ____ I am hearing impaired and will make use of the interpreter

Registration Fee: $125.00*
Saturday Luncheon: $ 15.00

Total Registration: $_____ + $15.00 Each Luncheon (Optional) = Total Amount Enclosed $_____

Please make your tax deductible check payable to: Colorado AIDS Project. Mail the registration form and check to:

COLORADO AIDS PROJECT
ATTENTION: AIDS CONFERENCE
P.O. BOX 18529
DENVER, COLORADO 80218

For further information, contact Peter Ralin at (303) 893-6300 or Terry Stewart at (303) 837-0166.

*$95.00 for registrations postmarked by December 7, 1990; $80.00 per participant for organizations registering five or more members in the same envelope postmarked by December 7, 1990.

SEPTEMBER 1990	Campylobacter, diarrhea	Chlamydia, sexually transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non A, Non B	Hepatitis, unspecified	Meningococcal meningitis	Post exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead		1													
Big Horn		5		1									1		
Blaine															
Broadwater															
Carbon		1	1								1				
Carter				1											
Cascade		16	2	3		2	1				8	1	2		
Chouteau															
Custer		1											1		
Daniels															
Dawson	1	1													
Deer Lodge															
Fallon			1												
Fergus		1	1												
Flathead			9	1							1				
Gallatin	1	12	2	1			1								
Garfield											1				
Glacier		7	1			4	2				1		1		
Golden Valley															
Granite															
Hill		3	2	1							1				
Jefferson			1			31									
Judith Basin															
Lake		8													
Lewis & Clark	1	8	2	1		1							3		
Liberty			1			1									
Lincoln		1	1									1			
McCone															
Madison			1												
Meagher															
Mineral															
Missoula	2	12	2	2		1	1							1	
Musselshell		1										2			
Park															
Petroleum															
Phillips		1													
Pondera															
Powder River															
Powell		1	1	1											
Prairie															
Ravalli													1		
Richland		2													
Roosevelt		2		1							1		1		
Rosebud		2											1	1	
Sanders		1													
Sheridan															
Silver Bow	1	6		1									2		
Stillwater															
Sweet Grass											1	1			
Teton															
Toole															
Treasure															
Valley															
Wheatland															
Wibaux															
Yellowstone		24	2	4			2	2					2	4	
MONTHLY TOTAL 1990	6	122	30	18	0	40	7	2	0	0	15	5	14	6	0
MONTHLY TOTAL 1989	17	112	28	20	0	24	2	0	1	0	4	6	5	20	0
MONTHLY TOTAL 1988	12	140	47	27	1	4	6	1	1	0	15	12	14	34	1
TOTAL TO DATE 1990	71	1113	131	166	9	127	55	7	4	10	23	44	87	35	18
TOTAL TO DATE 1989	46	803	71	220	5	31	33	1	2	1	50	55	36	89	32
TOTAL TO DATE 1988	40	191	100	262	6	25	33	8	1	1	47	141	44	91	5

OTHER DISEASES:

CHICKENPOX: Cascade - 3

CYTOMEGVIR: Ravalli - 1

HEPATITIS C: Gallatin - 1

LEGIONELLOSIS: Gallatin - 1

PERTUSSIS: Jefferson - 1, Missoula - 2
Yellowstone - 2

RUBELLA : Sanders - 1

Hib Vaccine (Haemophilus b Conjugate) Now Approved For Use In Infants

The Food and Drug Administration (FDA) recently approved the use of one type of Hib vaccine, HibTITER (manufactured by Lederle-Praxis Laboratories), for infants as young as two months of age.

The following is from a October 8, 1990 news release from the American Academy of Pediatrics (AAP):

"...The Haemophilus b bacterium causes meningitis, which can lead to brain damage and death, and is most likely to strike infants between the ages of two and 13 months. About 10,000 cases of meningitis occur annually in infants under 18 months. The Haemophilus organism also can cause pneumonia, epiglottitis (dangerous swelling of the throat) and infections of the joints.

Three Hib vaccines are currently licensed for children 15 months and older. The Food and Drug Administration (FDA) recently approved the use of one type of Hib vaccine, (HibTITER), for infants as young as two months of age. The infections that will be prevented by the vaccine are most common in younger infants.

Clinical trials of the vaccine in over 60,000 infants showed effective results with mild side effects and no serious adverse vaccine reactions. Other types of Hib vaccines may be licensed for infants in the future.

Among the AAP Committee's <u>provisional</u> recommendations:

> The (HibTITER) vaccine is recommended for all infants above the age of two months.
>
> Three doses of the vaccine should be given to infants younger than six months; ideally, at two, four and six months.
>
> Two doses of the vaccine should be given to infants who are first seen between seven and 11 months of age; one dose of the vaccine should be given for infants first seen between 12 and 14 months.
>
> All infants should receive a booster dose at 15 months.
>
> Any of the currently licensed conjugate vaccines can be used for the dose at 15 months, as they appear to be effective at that age.

Formal recommendations will be issued by the (AAP) Committee at a later date."

Editors note: The MMWR issue of October 5, 1990, also includes an article on this topic. The MMWR article includes the statement: "Previously unvaccinated children 12-14 months of age should receive one does; a booster dose after 15 months of age is recommended for these children." In the MMWR article, there is no reverence to children, vaccinated with Hib at less than 12 months of age, to receive a booster dose after 15 months of age. However, according to the Center for Disease Control, the booster dose after, 15 months, should be included for all infants. The Immunization Practices Advisory Committee is also planning to issue a complete statement on the use of Hib vaccine.

AAP Hotline for Physicians with Hib Vaccine Questions
Call: 1 800 433-9016

Hib Vaccine Supply Status for Public Clinics

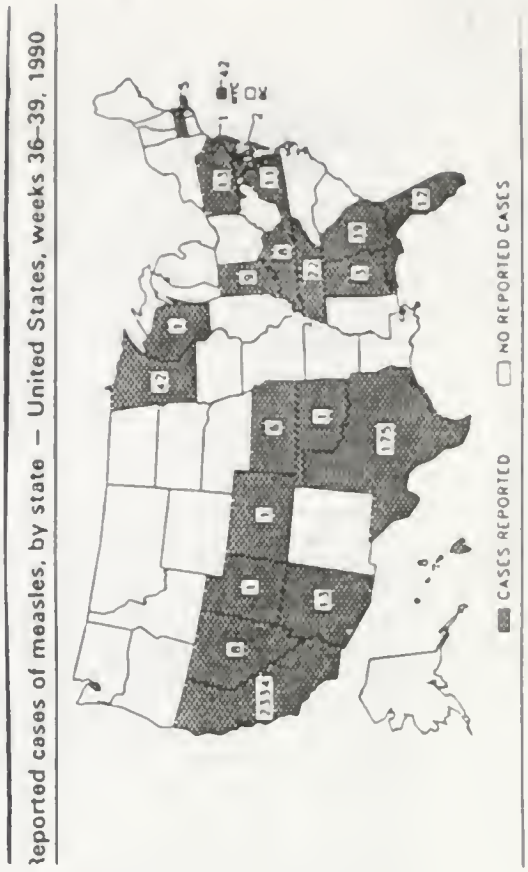
The Montana Immunization Program has provided Hib conjugate vaccine to public clinics for use in 15 month old children. At this time, the amount of vaccine available through the program is <u>not</u> sufficient to immunize children who <u>should</u> be vaccinated now that the Hib immunization schedule has changed to include children as young as 2 months of age.

According to the Immunization Division, Centers for Disease Control, the current federal contract for Hib vaccine purchase is with Connaught Laboratories (contract period: 6/24/90 - 6/23/91). The Connaught vaccine is not licensed for use in children younger than 15 months of age. It is not

expected that the Montana Immunization Program will be able to acquire additional HibTITER vaccine until June, 1991.

According to Lederle-Praxis, public agencies can purchase HibTITER vaccine at $9.00/dose with a minimum order of 200 doses. To place an order, or to talk to a Lederle-Praxis representative, call (406) 248-5021 and ask for Toni Pingree.

Karen Winden has recently joined the staff of the MDHES AIDS/STD Program. She will function as the Administrative Assistant to the program, replacing Beth Mitchell who has returned to college. Karen has transferred to the program from the Centralized Services Division of MDHES where she has worked for the past three years. She can be reached at 444-4740.



Volume: 14-9 **Month of:** SEPTEMBER 1990

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Montana State Department of Health and Environmental Sciences

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HIV/AIDS INFORMATION

Epidemiology of Syphilis in the United States - 1981 through 1989

Drs. Rolfs and Nakashima from the Centers for Disease Control recently reported on syphilis trends in the Journal of the American Medical Association (Vol. 264, No. 11).

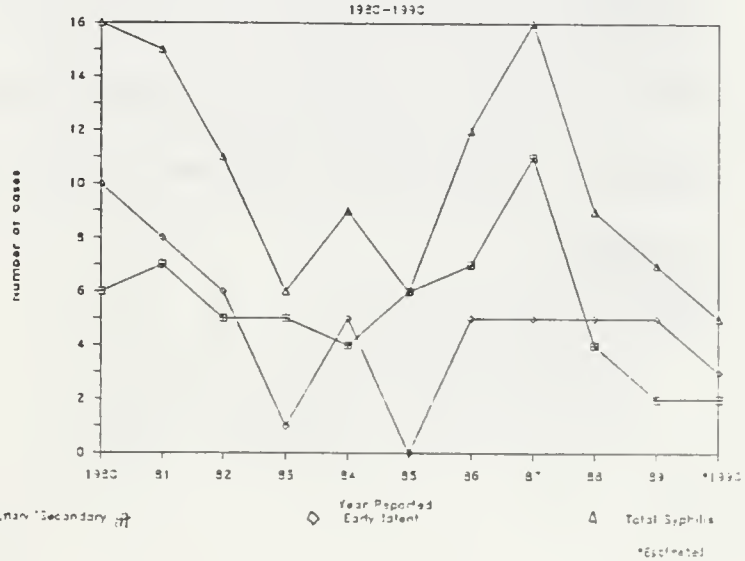
The article documented the increase of primary and secondary syphilis in the United States (34% between 1981 and 1989), the highest reported since 1949. The populations affected by the current syphilis epidemic are also described. For instance, from a peak in 1982, the incidents among white men decreased 69% by 1989. This is largely thought to be due to a change in sexual behavior by homosexual and bisexual men.

There have been significant racial differences in syphilis incidence during this period of time. Although incidence in black men and women between 1982 and 1985 decreased, there has been a sharp increase in syphilis in this population since that time resulting in a black to white ratio of 47.8 to 1 in 1989.

Much of the increases in the heterosexual minority inter-city populations in recent years, has been related to increased use of illegal drugs, especially cocaine. Various reports suggest that "drug use increases transmission of syphilis and other sexually transmitted diseases through drug related high risk sexual behaviors, such as prostitution." A concern that this increase in syphilis in recent years predicts a possible increase in human immuno-deficiency virus infection as well as genital ulceration appears to facilitate sexual transmission of HIV.

Montana's experience does not show a dramatic increase in syphilis during the past ten years as illustrated in figure 1 below, although there hasn't been the steady decline as has been noted with gonorrhea.

MONTANA: EARLY REPORTED SYPHILIS CASES



MONTANA DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES

MONTANA
RESIDENT AND NON-RESIDENT AIDS CASES*
Acquired Immunodeficiency Syndrome (AIDS)
Definitive and Presumptive AIDS Cases
Surveillance Report - 10/1/90 to 10/30/90

1. Disease Category — Adult/Adolescent/Pediatric

Disease Category	Cases (%)	Deaths (%)
PCP	31 (44)	23 (74)
Other Disease w/o PCP	38 (54)	22 (58)
KS Alone	2 (3)	0 (0)
No Diseases Listed	0 (0)	0 (0)
Total	71 (100)	45 (63)

2. Age — Adult/Adolescent/Pediatric

Age	Cases (%)
Under 13	1 (1)
13-19	1 (1)
20-29	20 (28)
30-39	31 (44)
40-49	12 (17)
Over 49	6 (8)
Unknown	0 (0)
Total	71 (100)

3. Race/Ethnicity — Adult/Adolescent/Pediatric

Race/Ethnicity	Cases (%)
White, Not Hispanic	60 (85)
Black, Not Hispanic	1 (1)
Hispanic	3 (4)
Native American	6 (8)
Unknown	1 (1)
Total	71 (100)

4. Exposure Category — Adult/Adolescent/Pediatric

Exposure Category	Males (%)	Females (%)	Total (%)
Homosexual or Bisexual Men	39 (64)	0 (0)	39 (56)
Intravenous (IV) Drug User	8 (13)	1 (11)	9 (13)
Homo/Bi IV Drug User	7 (11)	0 (0)	7 (10)
Hemophiliac	3 (5)	0 (0)	3 (4)
Heterosexual Contact	0 (0)	4 (44)	4 (6)
Transfusion With Blood/Products	0 (0)	2 (22)	2 (3)
Parent at risk/has AIDS/HIV	0 (0)	1 (22)	1 (3)
None of the Above/Other	4 (7)	2 (22)	6 (9)
Total	61 (100)	10 (100)	71 (100)

Source: Montana AIDS/STD Program, MDHES, through October 31, 1990.

*Includes 54 Montana AIDS cases and 17 cases reported to Centers for Disease Control from other states who moved to Montana.

As of October 31, 1990 there have been 268 cumulative positive HIV tests from 22,812 tests conducted through the MDHES Public Health Laboratory since 1985.

Nationally, as of September 30, 1990, 152,126 cases of AIDS and 93,775 deaths have been reported to the Centers for Disease Control.

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RISK BEHAVIOR ANALYSIS

Americans have become increasingly concerned about rates of disease and death related to several primary risk behaviors. This article describes nine different primary risk behaviors which impact the health and welfare of Montanans and all Americans. Risk behavior analysis is based on the premise that many diseases and untimely deaths can be prevented and that the identification of persons at risk can serve as a first step in a process to reduce particular risk behaviors and their unwanted and often unintended effects.

Each month since 1983, 99 Montanans have been surveyed by telephone to determine the prevalence of behaviors which contribute to risk of premature death and preventable disease. The survey which is conducted through the Preventive Health Services Bureau in the Montana Department of Health and Environmental Sciences is funded by the Centers for Disease Control (CDC), in Atlanta, Georgia. Presently 46 states participate in the Behavior Risk Surveillance System.

It is important to emphasize that these data in no way reflect how Montanans perceive their risk behaviors - whether, in fact, they recognize their behaviors as being actually or potentially harmful to them in either the short term or long term. This analysis is an examination of what adult Montanans said when they were asked about the occurrence of risk behaviors in their lives.

1. Use of Seatbelts. Adult Montanans as a whole have dramatically reduced their risk behavior with respect to nonuse of seatbelts. In 1984 slightly more than 46% "seldom or never" used seatbelts and by 1988, risk decreased to 12.1%. Categories of Montanans highest at risk for seldom or never using seatbelts are the unemployed, the less educated, those economically poorer, those not married, and younger people.

2. Sedentary Lifestyle. There was a small reduction of risk behavior among Montanans with respect to sedentary lifestyle. Categories of those less likely to engage in some type of physical activity were the widowed, retired, and those over 60 years in age, as well as the less educated and those economically poorer. Walking was named by adult Montanans overall as their most frequent physical activity, with gardening second, followed by a number of more rigorous activities such as running, jogging, bicycling, aerobics, etc.

3. Tobacco Use. There has been a decline in cigarette smoking by Montanans from 1984 to 1988. In 1984 about 30% smoked cigarettes, while by 1988 about 22% smoked. Those who were unemployed and those who were divorced or separated were among the categories of Montanans most at risk for cigarette smoking.

   Although the percent of adult Montanans who use smokeless tobacco seems low (prevalence is presently around 7%), Montanans' use of smokeless tobacco use is greater than most participating BRFSS states. There is also evidence that use of smokeless tobacco may be increasing. Use is most prevalent among young adults and males.

4. Use of Alcohol. About one-fifth of the adult Montana population engaged in acute drinking (having 5+ drinks on one occasion) throughout the five-year period of this study. There was a slight reduction in alcohol consumption, but in a statistical sense that reduction could simply be due to chance factors. Greater risk for alcohol consumption was indicated among those not married, young adults, males, and the unemployed.

5. Hypertension (High Blood Pressure). About one Montanan in five has been told they have high blood pressure, and that proportion has been stable throughout each of the years between 1984 and 1988. Hypertension is related to life-cycle stage in that those higher at risk were the retired, the widowed, and those over 60 years of age. Montanans with less education and those with less income were also at higher risk for hypertension.

6. Overweight. One-fifth of the adult Montana population is at risk for obesity and that proportion did not change significantly over the five-year period. Those at higher risk were the less educated, the middle-aged, the widowed, those over 60 years of age, and the retired.

7. Cholesterol. Only two years of data were available with respect to Montanans and cholesterol. About 58% of adult Montanans have been checked for cholesterol - thus about 42% may be at risk since they do not know their cholesterol level. Categories of Montanans who have not been checked were those who were unmarried, young adults, homemakers/students, and the unemployed. In general, young Montana adults have not been checked for cholesterol in comparison with the rest of the adult population.

8. Mammograms. More than 9 out of 10 adult Montana women have heard of mammograms; only 36% have actually had mammograms. Those who have not had mammograms were younger women, those not married, and students.

9. Routine Medical Checkups. About 60% of adult Montanans had a routine medical checkup during 1987 and 1988 combined. Categories of Montanans who had not had checkups were males, those 25-39 years of age, the employed, those in the higher income bracket ($35,000+), and those who were divorced or separated.

For a copy of the 1984-1988 Behavioral Risk Survey 5-Year Report, contact the Marsha McFarland in the Chronic Disease Prevention Program, phone 444-2555.

Additional Hib Vaccine for Public Clinics Soon To be Available

According to the Centers for Disease Control (CDC), additional federal funds have been secured for the purchase of Hib (haemophilus influenza type B) vaccine. CDC is expecting to renegotiate the Hib federal vaccine contract during December. After the Hib contract is renegotiated, and the funds are available, and the vaccine is received by the Montana Immunization Program, all public clinics should be able to start immunizing children as young as 2 months of age with Hib vaccine. Public clinics can expect an immediate notice, at any time in the near future, that the Hib (Praxis - HibTITER) vaccine provided by the Montana Immunization Program can be used for infants. Until the additional Hib vaccine supply can be assured, public clinics should continue to target the program-provided Hib vaccine at 15 month old children.

2nd Dose MMR Vaccine To Be Available At Public Clinics For Selected Populations

The Centers for Disease Control (CDC) has provided $83,200 to the Montana Immunization Program for the purchase of "second dose" MMR (measles, mumps, rubella) vaccine. Once the vaccine is received, it will be used in public clinics to help implement the new ACIP (Immunization Practice Advisory Committee) and AAP (American Academy of Pediatrics) recommendations for measles prevention. Consideration is being given to first target the vaccine for use in post-secondary freshmen. Strategies for immunizing school-age children will be based on MMR vaccine supplies. The school-age cohort which is being considered for the "2nd dose" MMR is the middle school and junior high enterers.

According to Walter Ornstein, M.D., Director, Division of Immunization , CDC, there is expected to be an immediate impact on college measles outbreaks if the new 2 dose MMR strategy is used. Also, within 4 years, there should be no measles outbreaks in colleges, and within 2 years most college measles cases will be eliminated since most measles seen in college are in freshmen and sophomores. Measles elimination success in colleges could be compared to that of the military where measles has been eliminated. All military recruits are vaccinated against the disease.

Jim Murphy has recently joined the staff of the AIDS/STD program. Jim will function as the surveillance coordinator and the coordinator of the AIDS Drug Reimbursement Program (ADRP). He will follow up reports of AIDS cases through statewide contacts with health providers and health departments to ensure proper reporting. As coordinator of the ADRP Jim will review applications for assistance to determine if the necessary criteria are met for approval.

Jim attended the University of Montana and received a Bachelors in Secondary Education, with an emphasis in General Science. Prior to joining the Health Department Jim had worked as an evaluator and program writer with the Montana Developmental Center in Boulder. Jim can be reached at 444-4744.

OCTOBER 1990	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals **	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead															
Big Horn		2		5											
Blaine															
Broadwater															
Carbon		2		1			1								
Carter															
Cascade		13		2		1						1			
Chouteau															
Custer															
Daniels															
Dawson		2													
Deer Lodge		2		1											
Fallon															
Fergus															
Flathead		3	5				1						1		
Gallatin		25	1		1	1							2		
Garfield															
Glacier		4				7	2						2		
Golden Valley															
Granite															
Hill		5		1											
Jefferson															
Judith Basin															
Lake		7				1									
Lewis & Clark		19	3	1		7							2	1	
Liberty															
Lincoln		1										1			
McCone															
Madison			2												
Meagher															
Mineral															
Missoula	2	15	1	3			2				1		3		
Mussalshell												2			
Park		2													
Petroleum															
Phillips		1													
Pondera															
Powder River															
Powell				1											
Prairie															
Ravalli		2													
Richland															
Roosevelt		2		3									1	2	
Rosebud		6	1	2							1				
Sanders		2													
Sheridan															
Silver Bow		4	2										3		
Stillwater												1			
Sweet Grass		1													
Teton		1													
Toole		2											1		
Treasure															
Valley															
Wheatland															
Wibaux															
Yellowstone	2	26		5		4							1		
MONTHLY TOTAL 19 90	4	149	15	26	1	21	6	0	0	0	2	5	16	3	0
MONTHLY TOTAL 19 89	6	144	29	18	2	14	2	0	0	1	9	1	24	2	5
MONTHLY TOTAL 19 88	9	133	17	26	1	148	3	0	0	0	11	18	10	27	4
TOTAL TO DATE 19 90	75	1322	146	192	10	31	61	7	4	10	75	44	103	38	18
TOTAL TO DATE 19 89	46	803	71	120	5	25	33	3	2	1	50	55	36	89	12
TOTAL TO DATE 19 88	40	1191	100	262	6		33	8	3	1	47	143	44	91	5

OTHER DISEASES: Aseptic Men: Gallatin-1 Bac Men Unspec:Cascade-1 Chickenpox: Carbon-2

Cytomegvir Ill: Gallatin-1 Legionellosis: Missoula-2 Pertussis: Jefferson-1, Missoula-1 Silverbow-1

Yersinia: Flathead-1

** Previous Month Totals

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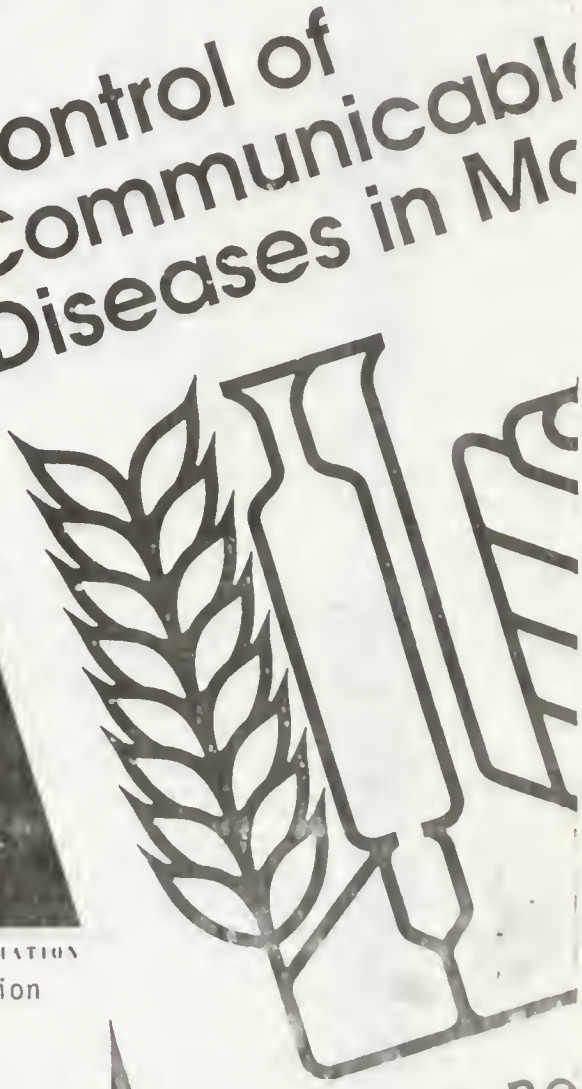

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VACCINE ADVERSE EVENT REPORTING SYSTEM

VAERS

24 Hour Toll-free information line 1-800-822-7967

Patient identity kept confidential

For CDC/FDA Use Only

VAERS Number _____

Date Received _____

Patient Name:

Last First M.I.

Address

City State Zip

Telephone no. (_____)_____

Vaccine administered by (Name):

Responsible Physician _____

Facility Name/Address

City State Zip

Telephone no. (_____)_____

Form completed by (Name):

Relation to ☐ Vaccine Provider ☐ Patient/Parent Patient ☐ Manufacturer ☐ Other

Address *(if different from patient or provider)*

City State Zip

Telephone no. (_____)_____

1. State	2. County where administered	3. Date of birth mm dd yy	4. Patient age	5. Sex ☐M ☐F	6. Date form completed mm dd yy

7. Describe adverse event(s) (symptoms, signs, time course) and treatment, if any

8. Check all appropriate:

- ☐ Patient died (date ___/___/___ mm dd yy)
- ☐ Life threatening illness
- ☐ Required emergency room/doctor visit
- ☐ Required hospitalization (_____days)
- ☐ Resulted in prolongation of hospitalization
- ☐ Resulted in permanent disability
- ☐ None of the above

9. Patient recovered ☐ YES ☐ NO ☐ UNKNOWN

10. Date of vaccination mm dd yy Time _____ AM PM

11. Adverse event onset mm dd yy Time _____ AM PM

12. Relevant diagnostic tests/laboratory data

13. Enter all vaccines given on date listed in no. 10

	Vaccine (type)	Manufacturer	Lot number	Route/Site	No. Previous doses
a.					
b.					
c.					
d.					

14. Any other vaccinations within 4 weeks of date listed in no. 10

	Vaccine (type)	Manufacturer	Lot number	Route/Site	No. Previous doses	Date given
a.						
b.						

15. Vaccinated at:
☐ Private doctor's office/hospital ☐ Military clinic/hospital
☐ Public health clinic/hospital ☐ Other/unknown

16. Vaccine purchased with:
☐ Private funds ☐ Military funds
☐ Public funds ☐ Other /unknown

17. Other medications

18. Illness at time of vaccination (specify)

19. Pre-existing physician-diagnosed allergies, birth defects, medical conditions (specify)

20. Have you reported this adverse event previously? ☐ No ☐ To health department ☐ To doctor ☐ To manufacturer

Only for children 5 and under

22. Birth weight _____ lb. _____ oz.

23. No. of brothers and sisters

21. Adverse event following prior vaccination (check all applicable, specify)

	Adverse Event	Onset Age	Type Vaccine	Dose no. in series
☐ In patient				
☐ In brother or sister				

Only for reports submitted by manufacturer/immunization project

24. Mfr. / imm. proj. report no.

25. Date received by mfr. / imm. proj.

26. 15 day report? ☐ Yes ☐ No

27. Report type ☐ Initial ☐ Follow-Up

Health care providers and manufacturers are required by law (42 USC 300aa-25) to report reactions to vaccines listed in the Vaccine Injury Table. Reports for reactions to other vaccines are voluntary except when required as a condition of immunization grant awards.

Form VAERS -1

DIRECTIONS FOR COMPLETING FORM

(Additional pages may be attached if more space is needed.)

GENERAL

- Use a separate form for each patient. Complete the form to the best of your abilities. Items 3, 4, 7, 8, 10, 11, and 13 are considered essential and should be completed whenever possible. Parents/Guardians may need to consult the facility where the vaccine was administered for some of the information (such as manufacturer, lot number or laboratory data.)
- Refer to the Vaccine Injury Table (VIT) for events mandated for reporting by law. Reporting for other serious events felt to be related but not on the VIT is encouraged.
- Health care providers other than the vaccine administrator (VA) treating a patient for a suspected adverse event should notify the VA and provide the information about the adverse event to allow the VA to complete the form to meet the VA's legal responsibility.
- These data will be used to increase understanding of adverse events following vaccination and will become part of CDC Privacy Act System 09-20-0136, "Epidemiologic Studies and Surveillance of Disease Problems". Information identifying the person who received the vaccine or that person's legal representative will not be made available to the public, but may be available to the vaccinee or legal representative.

SPECIFIC INSTRUCTIONS

Form Completed By — To be used by parents/guardians, vaccine manufacturers/distributors, vaccine administrators, and/or the person completing the form on behalf of the patient or the health professional who administered the vaccine.

Item 7 — Describe the suspected adverse event. Such things as temperature, local and general signs and symptoms, time course, duration of symptoms diagnosis, treatment and recovery should be noted.

Item 9 — Check "YES" if the patient's health condition is the same as it was prior to the vaccine, "NO" if the patient has not returned to the pre-vaccination state of health, or "UNKNOWN" if the patient's condition is not known.

Item 10 and 11 — Give dates and times as specifically as you can remember. If you do not know the exact time, please indicate "AM" or "PM" when possible if this information is known. If more than one adverse event, give the onset date and time for the most serious event.

Item 12 — Include "negative" or "normal" results of any relevant tests performed as well as abnormal findings.

Item 13 — List ONLY those vaccines given on the day listed in Item 10.

Item 14 — List ANY OTHER vaccines the patient received within four weeks of the date listed in Item 10.

Item 16 — This section refers to how the person who gave the vaccine purchased it, not to the patient's insurance.

Item 17 — List any prescription or non prescription medications the patient was taking when the vaccine(s) was given.

Item 18 — List any short term illnesses the patient had on the date the vaccine(s) was given (i.e., cold, flu, ear infection).

Item 19 — List any pre-existing physician-diagnosed allergies, birth defects, medical conditions (including developmental and/or neurologic disorders) the patient has.

Item 21 — List any suspected adverse events the patient, or the patient's brothers or sisters, may have had to previous vaccinations. If more than one brother or sister, or if the patient has reacted to more than one prior vaccine, use additional pages to explain completely. For the onset age of a patient, provide the age in months if less than two years old.

Item 26 — This space is for manufacturers' use only.

New System For Reporting Adverse Events Following Vaccination (VAERS)

Effective November 1, 1990, the new Vaccine Adverse Events Reporting System (VAERS) became operational, replacing the Monitoring System for Adverse Events Following Immunization (MSAEFI).

Prior to now, adverse events occurring after receipt of publicly purchased vaccines have been reported through the Montana Immunization Program to the Centers for Disease Control's MSAEFI. Adverse events occurring after receipt of privately purchased vaccine have been reported by the provider to the Food and Drug Administration's Adverse Drug Reporting System. The new VAERS replaces both previous reporting systems. The enclosed Table 1 describes which vaccines and adverse events are reportable under the National Childhood Vaccine Injury Act.

The following describes VAERS reporting requirements.

1. The Department of Health and Human Services (DHHS) has established VAERS to accept ALL reports of adverse events after the administration of ANY vaccine, in addition to those listed on the Table. Reports of serious adverse events (e.g., those that require a health care visit within 30 days) are encouraged over minor events.

   A contract to administer VAERS has been awarded to Evaluation Research Corporation (ERC) BioServices of Rockville, Maryland, with persons at CDC and FDA serving as co-project officers.

2. Instructions for completing the VAERS report form are on the back of the form. The most noticeable difference between the VAERS and MSAEFI Forms is that VAERS permits the adverse event to be described by the reporter in narrative format.

   Lay persons can also report an adverse event to VAERS. These individuals should be strongly encouraged, however, to allow the health care provider to report the event or to seek the assistance of a health professional in completing the form.

3. To ensure that physicians likely to administer vaccines in private practice are familiar with VAERS, ERC BioServices is mailing the VAERS report form and the Table to all licensed physicians in the U.S. in the specialties of family practice, general practice, pediatrics, internal medicine, obstetrics and gynecology, and emergency medicine. VAERS forms in these packets, as well as forms used for general publicity (e.g., enclosed in the Physician's Desk Reference), will contain an ERC return address.

4. For the public sector, camera-ready copies of the VAERS report form with the Montana Immunization Program return address are being printed and will be distributed in small quantities when available. In the meantime, you may use the enclosed copies and/or make photocopies of the form.

   You are to use the VAERS report form for reporting adverse events following vaccines administered on or after November 1, 1990.

   Before forwarding the VAERS report form to the Immunization Program, clinic staff should ensure that the following items on the VAERS form are completed and that the dates make chronological sense (e.g., date of birth precedes date of vaccination). These items are critical to the analysis of VAERS and are differentiated by their respective item numbers in a box on the form:

   Item 3: (Date of Birth) or Item 4 (Age)
   Item 7: (Describe adverse event)
   Item 8: (Check all appropriate)
   Item 10: (Date of vaccination)
   Item 11: (Adverse event onset date)
   Item 13: (Enter all vaccines given on date listed in No. 10)

5. The person completing the VAERS report form (the top right box) will receive a letter from VAERS acknowledging the receipt of the report form. If any of

the essential items are missing, the acknowledgement letter will note which and request that it be submitted from VAERS to the Montana State Coordinator, Immunization Program.

6. For the serious adverse events listed in Table 1, VAERS will send a reminder letter to the Immunization Program two weeks before the 60-day and 1-year follow-ups are due. We then will contact the appropriate provider to obtain the additional needed information for VAERS.

If you have any questions regarding the new system, please contact the Montana Immunization Program at 444-4740. We appreciate your assistance in monitoring adverse events following vaccination.

TABLE 1 Reportable events following immunization*

Vaccine Toxoid	Event		Interval from immunization
DTaP DTaP-[illegible] [illegible]	A	Anaphylaxis or anaphylactic shock	24 hours
	B	Encephalopathy (or encephalitis)†	7 days
	C	Shock-collapse or hypotonic-hyporesponsive collapse†	7 days
	D	Residual seizure disorder†	‡
	E	Any acute complication or sequela (including death) of above events	No limit
	F	See package insert§	(See package insert)
Measles Mumps and Rubella (MR MMR Td, T toxoid	A	Anaphylaxis or anaphylactic shock	24 hours
	B	Encephalopathy (or encephalitis)†	15 days for measles, mumps, and rubella vaccines; 7 days for DT, Td, and T toxoids
	C	Residual seizure disorder†	‡
	D	Any acute complication or sequela (including death) of above events	No limit
	E	(See package insert)§	(See package insert)
Oral Poliovirus vaccine	A	Paralytic poliomyelitis – in a nonimmunodeficient recipient – in an immunodeficient recipient – in a vaccine-associated community case	30 days 6 months No limit
	B	Any acute complication or sequela (including death) of above events	No limit
	C	See package insert)§	(See package insert)
Inactivated Poliovirus vaccine	A	Anaphylaxis or anaphylactic shock	24 hours
	B	Any acute complication or sequela (including death) of above event	No limit
	C	(See package insert)§	(See package insert)

*Events listed are required by law to be reported to the U.S. Department of Health and Human Services; however, VAERS will accept all reports of suspected adverse events after the administration of any vaccine.

†Aids to interpretation

- Shock-collapse or hypotonic-hyporesponsive collapse may be evidenced by signs or symptoms such as decrease in or loss of muscle tone, paralysis (partial or complete), hemiplegia, hemiparesis, loss of color or change of color to pale white or blue, unresponsiveness to environmental stimuli, depression of or loss of consciousness, prolonged sleeping with difficulty arousing, or cardiovascular or respiratory arrest.
- Residual seizure disorder may be considered to have occurred if no other seizure or convulsion unaccompanied by fever or accompanied by a fever of < 102 F occurred before the first seizure or convulsion after the administration of the vaccine involved.
  AND, if in the case of measles-, mumps-, or rubella-containing vaccines, the first seizure or convulsion occurred within 15 days after vaccination; OR in the case of any other vaccine, the first seizure or convulsion occurred within 3 days after vaccination.
  AND, if two or more seizures or convulsions unaccompanied by fever or accompanied by a fever of < 102 F occurred within 1 year after vaccination.
- The terms seizure and convulsion include grand mal, petit mal, absence, myoclonic, tonic-clonic, and focal motor seizures and signs.
- Encephalopathy means any substantial acquired abnormality of, injury to, or impairment of brain function. Among the frequent manifestations of encephalopathy are focal and diffuse neurologic signs, increased intracranial pressure, or changes lasting ≥6 hours in level of consciousness, with or without convulsions. The neurologic signs and symptoms of encephalopathy may be temporary with complete recovery, or they may result in various degrees of permanent impairment. Signs and symptoms such as high-pitched and unusual screaming, persistent unconsolable crying, and bulging fontanel are compatible with an encephalopathy, but in and of themselves are not conclusive evidence of encephalopathy. Encephalopathy usually can be documented by slow wave activity on an electroencephalogram.

§Refer to the CONTRAINDICATION section of the manufacturer's package insert for each vaccine.

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VOL. 14-11 NOVEMBER, 1990

Montana State Department of Health and Environmental Sciences

HIV/AIDS INFORMATION

AIDS Drug Reimbursement Program

Montana's AIDS Drug Reimbursement Program (ADRP) is projecting a budget surplus for the fiscal year of 1990. We have applied for an extension that allows us to utilize the unused funds during the next year. In addition to the unused funds, we are expecting full funding in 1991. The ADRP is designed to serve HIV infected individuals who may benefit from Zidovudine (AZT). Physician certification and a prescription is required. Financial requirements include Medicaid denial and ineligibility for any services which may be liable to pay all or part of the applicants medical costs. In addition, each applicant must provide evidence that the cost for AZT will create a severe financial burden. Thirty (30) Montanans have been served by the program since 1988. Currently, eighteen (18) clients are enrolled and receiving reimbursement for AZT.

In early January we are planning to announce a few minor changes in the program. We hope to clarify the eligibility requirements and simplify the application procedure. In addition, we plan to increase awareness of the services provided by the program by mailing to all Montana physicians.

If you have any questions, comments or suggestions regarding the ADRP, please call or write Jim Murphy, Surveillance Coordinator at 444-4740.

Through our contacts with physicians and counseling/testing sites, we hope to inform all people able to benefit from AIDS Drug therapies of the assistance available.

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HIV Early Intervention Project Missoula City-County Health Department Serving Western Montana

The Missoula City-County Health Department with funding assistance from the Missoula AIDS Fund, Inc., a non-profit organization, is sponsoring the HIV Early Intervention Program. The program is designed to provide free services, to people from western Montana who are HIV positive, in a safe, confidential setting.

The goal of the project is to help HIV positive individuals explore and find ways to maintain optimum physical and emotional health. To achieve this goal, education, support and medical and laboratory evaluations are provided.

The services are not meant to replace medical care. The goal of the project is to provide an initial source of information about HIV infection and treatment, including baseline blood tests, that will help each person adjust to and live with their infection. If an individual does not have a doctor, the program can provide the names of physicians who are knowledgeable about HIV infection and sensitive to the HIV positive patient.

All services are provided free of charge. Donations to help cover the cost of the services are gladly accepted.

MONTANA DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES

MONTANA
RESIDENT AND NON-RESIDENT AIDS CASES[1]
Acquired Immunodeficiency Syndrome (AIDS)
Definitive and Presumptive AIDS Cases
Surveillance Report - 11/1/90 to 11/30/90

1.

Disease Category	Adult/Adolescent/Pediatric Cases (%)	Deaths (%)
PCP	31 (44)	23 (74)
Other Disease w/o PCP	38 (54)	22 (58)
KS Alone	2 (3)	0 (0)
No Diseases Listed	0 (0)	0 (0)
Total	71 (100)	45 (63)

2.

Age	Cases (%)
Under 13	1 (1)
13-19	1 (1)
20-29	20 (28)
30-39	31 (44)
40-49	12 (17)
Over 49	6 (8)
Unknown	0 (0)
Total	71 (100)

3.

Race/Ethnicity	Adult/Adolescent/Pediatric Cases (%)
White, Not Hispanic	60 (85)
Black, Not Hispanic	1 (1)
Hispanic	3 (4)
Native American	6 (8)
Unknown	1 (1)
Total	71 (100)

4.

Exposure Category	Adult/Adolescent/Pediatric Males (%)	Females (%)	Total (%)
Homosexual or Bisexual Men	40 (65)	0 (0)	40 (56)
Intravenous (IV) Drug User	8 (13)	1 (11)	9 (13)
Homo/Bi IV Drug User	7 (11)	0 (0)	7 (10)
Hemophiliac	3 (5)	0 (0)	3 (4)
Heterosexual Contact	0 (0)	4 (44)	4 (6)
Transfusion With Blood/Products	0 (0)	2 (22)	2 (3)
[2]Perinatal Transmission	0 (0)	1 (22)	1 (1)
None of the Above/Other	4 (6)	1 (22)	5 (7)
Total	62 (100)	9 (100)	71 (100)

Source: Montana AIDS/STD Program, MDHES, through November 30, 1990.

[1]Includes 54 Montana AIDS cases and 17 cases reported to Centers for Disease Control from other states who moved to Montana.

As of November 30, 1990 there have been 272 cumulative positive HIV tests from 23,380 tests conducted through the MDHES Public Health Laboratory since 1985.

Nationally, as of October 31, 1990, 152,231 cases of AIDS and 94,375 deaths have been reported to the Centers for Disease Control.

[2]Transmission from an infected mother to her fetus or infant during the perinatal period.

1991 Funding HIV/AIDS Prevention Education

Back in the summer and fall of 1990, there was discussion from the CDC regarding the HOPE amendment and the Ryan White CARE Act of 1990. There was concern over funding cuts for HIV/AIDS prevention education because of HOPE and over the treatment implications of Ryan White.

The MDHES AIDS/STD Program learned in November how much money it will be receiving in 1991 for Health Education/Risk Reduction (HERR) and Counseling, Testing, Referral and Partner Notification (CTRPN) activities. The program will receive funding at a level equal to 1990. This will allow the local HERR/CTRPN sites and community-based organizations to continue in their efforts to provide prevention education to those individuals most at risk for HIV infection.

There will also be additional funding from the Ryan White Act announced in early 1991. The intent of the additional funding is to provide better intervention services for persons who are HIV positive as well as more extensive home-based services for persons with AIDS.

HIV Counseling Techniques Course

Throughout 1991, the MDHES AIDS/STD Program will continue to offer the "HIV Counseling Techniques" Course. The course is open to individuals involved in counseling persons who request the HIV test. It is a two-day course and full participation in both days is required. A combination of teaching methods with an emphasis on role playing is utilized to most effectively prepare the participant to counsel persons seeking the HIV test.

We are planning to offer the course three times in different cities around the state. By announcing the schedule now, we are hoping you can plan to attend the course closest to you. The offerings are as follows:

February 21 - 22, 1991:	Helena
June 26 - 27, 1991:	Billings
October 23 - 24, 1991:	Missoula

There is no charge for the course and more information about registration will be forthcoming as it gets closer to the dates. For more information, contact Kathy Andersen at 444-4740.

New Health Educator AIDS/STD Program

Amy Harris has recently joined the Montana AIDS/STD Program as a Health Educator/Disease Intervention Specialist. She is replacing Rhonda Forrette. Amy has been studying and working with HIV/AIDS education for the past five years in Washington State.

She recently graduated from the Evergreen State College where she helped establish an AIDS education program through the Student Health Center. She also coordinated the Evergreen State AIDS Symposium - a two day inter-disciplinary conference for the campus and local community.

Among her other responsibilities with the MDHES AIDS/STD Program, Amy will be involved with HIV education for the developmentally disabled and for IVDAs. You can reach Amy at 444-4740.

New Field Health Officer Hired For Immunization/Communicable Disease Programs

Mark Peacock joined the Department on December 4th as a Field Health Officer. The position had recently been vacated by Harriet Humes, RN, who accepted a nursing position at the Montana Developmental Center, Boulder. Mark's background includes experience as an STD investigator in North Dakota, has been a teacher at the High School level and has worked in medical and research laboratories. His orientation to the FHO position will take some time. This will include course work in disease epidemiology, and the Centers For Disease Control courses: Vaccine Preventable Disease Epidemiology, Prevention and Control and Introduction to Sexually Transmitted Disease Intervention (ISTDI). Of course, during the training period the program will be short staffed and our priority will continue to be responding to disease reports, ensuring vaccine delivery and safety, and assisting schools in meeting the Immunization Law requirements. The Field Health Officers (Debbie Schneider and Stan Strom) will continue to be available to assist you. We are excited about having Mark on board.

NOVEMBER 1990	Campylobacter, diarrhea	Chlamydia, sexually transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non A, Non B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals **	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead															
Big Horn		2		1							1				
Blaine		2													
Broadwater															
Carbon															
Carter															
Cascade		13	2	1		3	1				1	2			
Chouteau															
Custer															
Daniels															
Dawson		1													
Deer Lodge															
Fallon															
Fergus											1				
Flathead		1	1								1		2		
Gallatin	1	22	1	1							1				
Garfield															
Glacier		4													
Golden Valley															
Granite															
Hill		7		1											
Jefferson															
Judith Basin															
Lake		4		2											
Lewis & Clark		5	2			1									
Liberty															
Lincoln							1								
McCone															
Madison															
Meagher															
Mineral															
Missoula	1	16	1	4	2		1						2		
Musselshell											1				
Park	1	1												2	
Petroleum															
Phillips															
Ponders	1														
Powder River		1													
Powell															
Prairie															
Ravalli		1													
Richland															
Roosevelt		1	1	1											
Rosebud		3		2											
Sanders															
Sheridan															
Silver Bow		2	1												
Stillwater															
Sweet Grass															
Teton															
Toole															
Treasure															
Valley															
Wheatland															
Wibaux															
Yellowstone	1	35	2	3									1		
MONTHLY TOTAL 1990	5	121	11	16	2	4	3	0	0	0	6	2	5	2	0
MONTHLY TOTAL 1989	1	111	17	32	0	6	3	1	0	0	2	1	9	5	0
MONTHLY TOTAL 1988	8	150	7	36	1	3	7	0	0	0	4	12	4	24	12
TOTAL TO DATE 1990	80	270	157	208	12	152	64	7	2	10	81	46	108	40	18
TOTAL TO DATE 1989	46	803	71	120	5	31	33	3	2	1	50	55	36	89	12
TOTAL TO DATE 1988	40	1191	100	262	6	25	33	8	3	1	47	143	44	91	5

OTHER DISEASES: ASEPTIC MEN: Gallatin - 1 CHICKENPOX: Roosevelt - 10
CYTOMEGVIR ILL: Ravalli - 1, Silver Bow - 1 LEGIONELLOSIS - Gallatin - 1
PERTUSSIS: Yellowstone - 1 RUBELLA - Gallatin - 1 YERSINIA ENT.: Flathead - 1

**Previous Month Totals

* *

Invitation for Bid

MDHES is seeking to contract with an organization or organizations that have the capability and experience to provide home care services to low income individuals infected with Human Immunodeficiency Virus (HIV) who require routine use of medical services to prevent or compensate for serious deterioration of health. A major objective of the program is to avoid long term or repeated care as an inpatient or resident in a hospital, nursing facility or other institution by providing home and community based health care.

Qualified provider organizations will conduct eligibility assessments, provide care management and personal care services as needed. Up to four contracts will be awarded for a total of $67,250. Bids must contain a general work plan for accomplishing all tasks, a statement of general availability of personnel to perform the tasks and estimated costs and method of calculating these costs. Prospective providers will be evaluated on written proposals. For a list of evaluation criteria or further information, please contact Bruce Desonia at 444-4740.

* *

* *

Chlamydial Infections

Chlamydia trachomatous is the most common sexually transmitted disease in Montana. During the first nine months of this year there were almost seven times more cases of chlamydia than gonorrhea reported in Montana (1,182 vs. 176).

Culture and nonculture methods for diagnosis of C. trachomatis are now available. Appropriate use of these diagnostic tests is strongly encouraged, especially for screening asymptomatic high-risk women in whom infection would otherwise be undetected. However, in clinical settings where testing for chlamydia is not routine or available, treatment often is prescribed on the basis of clinical diagnosis or as co-treatment for gonorrhea. In clinical settings, periodic surveys should be performed to determine local chlamydial prevalence in patients with gonorrhea. Priority groups for chlamydia testing, if resources are limited, are high-risk pregnant women, adolescents, and women with multiple sexual partners.

Results of chlamydial tests should be interpreted with care. The sensitivity of all currently available laboratory tests for C. trachomatis tests is substantially less than 100%; thus, false-negative tests are possible. Although the specificity of nonculture tests has improved substantially, false-positive test results may still occur with nonculture tests. Persons with chlamydial infections may remain asymptomatic for extended periods of time.

Treatment of Uncomplicated Urethral, Endocervical, or Rectal C. trachomatis Infections

Recommended Regimen:

Doxycycline 100 mg orally 2 times a day for 7 days

OR

Tetracycline 500 mg orally 4 times a day for 7 days.

Alternative Regimen:

Erythromycin base 500 mg orally 4 times a day or equivalent salt for 7 days

OR

Erythromycin ethylsuccinate 800 mg orally 4 times a day for 7 days.

If erythromycin is not tolerated because of side effects, the following regimen may be effective:

Sulfisoxazole 500 mg orally 4 times a day for 10 days or equivalent.

Test of Cure

Because antimicrobial resistance of C. trachomatis to recommended regimens has not been observed, test-of-cure evaluation is not necessary when treatment has been completed.

Treatment of C. trachomatis in Pregnancy

Pregnant women should undergo diagnostic testing for C. trachomatis. N. gonorrhoeae and syphilis, if possible, at their first prenatal visit and, for women at high risk during the third trimester. Risk factors for chlamydial disease during pregnancy include young age (<25 years), past history or presence of other STD, a new sex partner within the preceding 3 months and multiple sex partners. Ideally, pregnant women with gonorrhea should be treated for chlamydia on the basis of diagnostic studies, but if chlamydial testing is not available, treatment should be given because of the high likelihood of coinfection.

Recommended Regimen:

Erythromycin base 500 mg orally 4 times a day for 7 days

If this regimen is not tolerated, the following regimens are recommended:

Alternative Regimen:

Erythromycin base 250 mg orally 4 times a day for 14 days

OR

Erythromycin ethylsuccinate 800 mg orally 4 times a day for 14 days

Alternative if Erythromycin Cannot Be Tolerated:

Amoxicillin 500 mg orally 3 times a day for 7 days (limited data exist concerning this regimen).

Erythromycin estolate is contra-indicated during pregnancy, since drug-related hepatoxicity can result.

Sex Partners of Patients with C. trachomatis Infections

Sex partners of patient who have C. trachomatis infection should be tested and treated for C. trachomatis if their contact was within 30 days of onset of symptoms. If testing is not available, they should be treated with the appropriate antimicrobial regimen.

Reference:

Sexually Transmitted Diseases Treatment Guidelines (September 1990), Centers for Disease Control, Public Health Service

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VOL. 14-12 DECEMBER, 1990

Montana State Department of Health and Environmental Sciences

* *
* HIV/AIDS INFORMATION *
* *

THE STD PROBLEM IN THE UNITED STATES

Sexually transmitted diseases continue as one of the Nation's most serious public health problems. Not only is HIV infection the most devastating public health problem of this century, but also infectious syphilis has continued increases unprecedented since the advent of penicillin therapy; resistant gonococcal infection is steadily increasing; chlamydial infections account for twice as many cases as gonorrhea; and studies on human papillomavirus even more clearly associate it with development of cervical dysplasia.

Estimates of STD which threaten the health of Americans, primarily adolescents and young adults, have increased to over 12 million cases each year. Sixty-three percent of all STD cases occur among persons less than 25 years of age. Two and an half million teenagers are affected with an STD annually.

Additionally, an estimated one million Americans are infected with the human immunodeficiency virus (HIV). Preventing the spread of HIV and controlling the development of AIDS is the Nation's number one public health priority. Because of its fatal implications, AIDS is the most important STD.

After death, the most serious public health complications caused by STD are PID, infertility, ectopic pregnancy, adverse pregnancy outcome, infant pneumonia, infant death, mental retardation, immune deficiencies and neoplasia. Women and children bear an inordinate share of the physical and emotional burden of non-AIDS STDs.

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* *
* INDEX *
* *
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STD Problem in the U.S.....1
Resident & Non-Resident AIDS.....2
Montana Morbidity - December.....3
Malaria Prevention.....4

JUST A REMINDER
HIV Counseling Techniques Course

The MDHES AIDS/STD Program will be offerin the "HIV Counseling Techniques" Course Helena on Thursday and Friday, February 21 22, 1991. The course is open to thos individuals involved in counseling peopl seeking the HIV test. Full participatio in both days is required. To most effec tively prepare participants for HI counseling, the course places an emphasi on role playing.

Enrollment is limited and there are alread a number of people wait-listed. If you ar interested in attending, please call Kath Andersen at 444-4740 by Friday, February 1

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REMINDER

Just a little reminder to those of you who have a Dickson temperature recorder - the batteries and pens need to be changed yearly. If you have not done so, this would be a good time to check them.

MONTANA DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES

MONTANA
RESIDENT AND NON-RESIDENT AIDS CASES[1]
Acquired Immunodeficiency Syndrome (AIDS)
Definitive and Presumptive AIDS Cases
Surveillance Report - 12/1/90 to 12/31/90

1. Disease Category

Disease Category	Adult/Adolescent/Pediatric Cases (%)	Deaths (%)
PCP	34 (43)	24 (71)
Other Disease w/o PCP	43 (54)	25 (58)
KS Alone	2 (3)	0 (0)
No Diseases Listed	0 (0)	0 (0)
Total	79 (100)	49 (62)

2. Age

Age	Cases (%)
Under 13	2 (3)
13-19	1 (1)
20-29	23 (29)
30-39	33 (42)
40-49	13 (16)
Over 49	7 (9)
Unknown	0 (0)
Total	79 (100)

3. Race/Ethnicity

Race/Ethnicity	Adult/Adolescent/Pediatric Cases (%)
White, Not Hispanic	66 (84)
Black, Not Hispanic	1 (1)
Hispanic	3 (4)
Native American	8 (10)
Unknown	1 (1)
Total	79 (100)

4. Exposure Category

Exposure Category	Adult/Adolescent/Pediatric Males (%)	Females (%)	Total (%)
Homosexual or Bisexual Men	47 (67)	0 (0)	47 (59)
Intravenous (IV) Drug User	8 (11)	1 (11)	9 (11)
Homo/Bi IV Drug User	8 (11)	0 (0)	8 (10)
Hemophiliac	3 (4)	0 (0)	3 (4)
Heterosexual Contact	0 (0)	4 (44)	4 (5)
Transfusion With Blood/Products	0 (0)	2 (22)	2 (3)
[2]Perinatal Transmission	1 (1)	1 (11)	2 (3)
None of the Above/Other	3 (4)	1 (11)	4 (5)
Total	70 (100)	9 (100)	79 (100)

Source: Montana AIDS/STD Program, MDHES, through December 31, 1990.

[1]Includes 59 Montana AIDS cases and 20 cases reported to Centers for Disease Control from other states who moved to Montana.

As of December 31, 1990 there have been 276 cumulative positive HIV tests from 23,817 tests conducted through the MDHES Public Health Laboratory since 1985.

Nationally, as of November 30, 1990, 157,225 cases of AIDS and 98,530 deaths have been reported to the Centers for Disease Control.

[2]Transmission from an infected mother to her fetus or infant during the perinatal period.

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DECEMBER 1990	Campylobacter, diarrhea	Chlamydia, sexually transmitted * * *	Giardiasis	Gonococcal disease * * *	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead															
Big Horn		2		1	1										
Blaine		2					1								
Broadwater															
Carbon															
Carter															
Cascade		13	1	1	1		1								
Chouteau															
Custer							1								
Daniels															
Dawson		1					1								
Deer Lodge											1				
Fallon															
Fergus															
Flathead	1	1	3												
Gallatin	1	22		1		1									
Garfield															
Glacier		4				3	1								
Golden Valley	1														
Granite															
Hill		7		1			2						3		
Jefferson															
Judith Basin															
Lake		4		2									1		
Lewis & Clark		5	2										1	1	
Liberty															
Lincoln															
McCone															
Madison															
Meagher															
Mineral															
Missoula	1	16		4			1						1		
Musselshell			2												
Park		1													
Petroleum															
Phillips															
Pondera						2									
Powder River		1													
Powell															
Prairie															
Ravalli		1	1												
Richland															
Roosevelt		1		1											
Rosebud		3		2											
Sanders															
Sheridan															
Silver Bow	1	2													
Stillwater															
Sweet Grass															
Teton															
Toole															
Treasure															
Valley															
Wheatland															
Wibaux															
Yellowstone	1	35		3			1								
MONTHLY TOTAL 19 90	6	121	9	16	2	6	9	0	0	0	1	0	6	1	0
MONTHLY TOTAL 19 89	3	116	10	32	1	1	6	0	0	0	0	3	6	5	15
MONTHLY TOTAL 19 88	5	150	13	36	0	8	3	0	0	0	9	10	8	49	7
TOTAL TO DATE 19 90	86	270	166	208	14	158	73	7	4	10	82	46	14	41	18
TOTAL TO DATE 19 89	46	803	71	120	5	31	33	3	2	1	50	55	36	89	12
TOTAL TO DATE 19 88	40	1191	100	262	6	25	33	8	3	1	47	143	44	91	5

OTHER DISEASES:

ASEPTIC MEN: Sheridan - 1

CHICKENPOX: Cascade - 1, Gallatin - 11, Lewis & Clark - 5

**This Reflects November's Totals

Malaria Prevention: Revised Dosing Regimen for Mefloquine Prophylaxis

A U.S. interagency group on malaria prevention has recently reviewed documented experience on the effectiveness and tolerance of mefloquine (Lariam) for malaria prophylaxis. Based on this review, the group has proposed a change in the dosing regimen for malaria prophylaxis with mefloquine. Consequently, the Centers for Disease Control has revised the dosing recommendations for mefloquine use. The new regimen consists of a single dose of mefloquine to be taken weekly, starting one week before travel. Prophylaxis should be continued weekly during travel in malarious areas and for 4 weeks after a person leaves such areas.

This notice updates the information in the following publications:

1. CDC, recommendations for the Prevention of Malaria. MMWR 1990; RR-304;

2. CDC, Health Information for International Travel 1990

HHS Publication No. (CDC) 90-8280-98. Detailed information about the prevention of malaria is available on the CDC Telephone Information System at (404)332-4555.

Information about the availability of mefloquine can be obtained from the manufacturer at 1-800-526-6367.

Reported by: Malaria Br., Div. of Parasitic Diseases, Centers for Infectious Diseases, CDC.

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Immunization Computer Programs for Schools and Clinics

The Montana Immunization Program has had several requests from both school nurses and immunization clinics regarding computer programs. They would like to computerize their immunization data but do not want to "re-invent the wheel." If your health department or school has a computerized immunization record and/or management program, which you think may be of value to others in Montana, please send 1) copies of print-outs or computer program descriptions, and, 2) an address, name and phone number of a contact person to: The Montana Immunization Program, MDHES, Cogswell Building, Helena, MT 59620.

Future editions of the Montana Morbidity Report will include a summary of this information.

Volume: 14-12 **Month of:** DECEMBER 1990

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MONTANA MORBIDITY REPORT

Volume: 15 - 1990 ANNUAL SUMMARY

MONTANA MORBIDITY REPORT. Pub. No. 397830. Published monthly with an extra issue for March by the Health Services Division of the Department of Health and Environmental Sciences, Cogswell Building, Helena, MT 59620.

Distributed without charge to health care providers at a cost of 6¢ per copy for printing and 7¢ per copy mailing.

1990 ANNUAL SUMMARY	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead	1	21	1	1											
Big Horn		37	2	16	1	3					2	1	5	2	2
Blaine		16					9		1						1
Broadwater		1													
Carbon		13	1	3			1				3	2			
Carter				1											
Cascade	5	166	18	19	2	6	4				29	9	5		3
Chouteau		2									2	1			
Custer		25		4			1				1	1	2		
Daniels															
Dawson	4	7					3						1		
Deer Lodge		8	7	2	1		2				1				
Fallon			1												
Fergus	1	12	13		2						1	2			
Flathead	7	40	35	3		6	9	1			7		10	1	4
Gallatin	7	197	13	11	2	3	2			1	6		10	1	
Garfield											2				
Glacier		47	2	5	1	35	9	1	3		3		3		1
Golden Valley	1	1													
Granite			1												
Hill	1	83	6	4		5	8				1		4		2
Jefferson		9	1	4		38									1
Judith Basin				1								1			
Lake		66		17	1	17							1	2	
Lewis & Clark	4	107	18	6		10	2			3	1	1	9	2	2
Liberty			1			1									
Lincoln		10	1	2		2	1				2	1			
McCone		1									1	1			

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1990 Annual
summary

AIDS - 20

AMEBIASIS - 2
- Gallatin - 1
- Sheridan - 1

ASEPTIC MENINGITIS - 7
- Gallatin - 2
- Missoula - 1
- Sanders - 1
- Sheridan - 1
- Stillwater - 1
- Yellowstone -1

CHANCROID - 1
- Silver Bow - 1

CHICKENPOX - 196
- Carbon - 2
- Cascade - 87
- Flathead - 1
- Gallatin - 16
- Hill - 20
- Judith Basin - 22
- Lake - 10
- Lewis & Clark - 8
- Meagher - 7
- Powell - 1
- Roosevelt - 11
- Silver Bow - 2
- Wheatland - 1
- Yellowstone - 8

COLORADO TICK FEVER - 12
- Beaverhead - 3
- Big Horn - 2
- Missoula - 3
- Powell - 1
- Ravalli - 1
- Silver Bow - 1
- (Unknown) - 1

CYTOMEGALOVIRAL ILLNESS - 12
- Beaverhead - 1
- Cascade - 3
- Gallatin - 3
- Ravalli - 3
- Silver Bow - 1
- Yellowstone - 1

LEGIONELLOSIS - 6
- Flathead - 1
- Gallatin - 2
- Missoula - 2
- Rosebud - 1

MALARIA - 1
- Gallatin - 1

MEASLES, IMPORTED - 6
- Lewis & Clark - 1
- Missoula - 1
- Flathead - 4

MUMPS - 1
- Flathead - 1

PERTUSSIS - 36
- Jefferson - 2
- Missoula - 3
- Ravalli - 27
- Silver Bow - 1
- Yellowstone - 3

ROCKY MOUNTAIN SPOTTED FEVER - 5
- Ravalli - 2
- Silver Bow - 1
- Yellowstone - 2

RUBELLA - 15
- Big Horn - 1
- Deer Lodge - 1
- Gallatin - 11
- Phillips - 1
- Sanders - 1

SYPHILIS, PRIMARY - 2
- Broadwater - 1
- Yellowstone - 1

SYPHILIS, SECONDARY - 1
- Yellowstone - 1

SYPHILIS, EARLY LATENT - 5
- Cascade - 1
- Deer Lodge - 1
- Missoula - 1
- Powell - 2

SYPHILIS, LATE LATENT - 2
- Gallatin - 1
- Hill - 1

SYPHILIS, NEUROLOGIC - 1
- Cascade - 1

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Malaria Prevention: Revised Dosing Information about the availability of